

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4032 CERTIFICATE OF DEATH

04033

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 8 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 915 N. Market St.				d. STREET ADDRESS 915 N. Market St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mary Middle Roetta Last Boone				4. DATE OF DEATH Month April Day 4th Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 2-1866	
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months 91 Days 4 Hours 57		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Indiana	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Royal H. Davis				14. MOTHER'S MAIDEN NAME Sarah Ann Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Frederick-Md. Mrs. Geo. M. Wachter-915 N. Market St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Stomach DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 151X DUE TO (c) 2 y 10							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Apr 3 , 19 54 , to Apr 3 , 19 57 , that I last saw the deceased alive on Apr 3 , 19 57 , and that death occurred at 1:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) North Market St.-Frederick-Md. DATE SIGNED 4-4-57							
ACTUAL SIGNATURE H F Kline				M.D. Dr. Horace F. Kline-Sr.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-7-1957		22c. NAME OF CEMETERY OR CREMATORY New Lisbon Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Union City-Indiana	
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Cline & Son ADDRESS Frederick-Maryland				24a. REC'D BY REGISTRAR 8 April 1957		24b. REGISTRAR'S SIGNATURE Eligabeth G. Heick	

BUREAU V. S.

APR 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4933

CERTIFICATE OF DEATH

04034

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>Since 1941</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>20 East South Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>ALPHUS</u> Last <u>BUCHANAN</u>				4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>28 Dec 1872</u>	
9. AGE (In years and birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Brakeman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Elizabeth M. Buchanan</u> Address <u>(Same as item #1)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>298X</u> DUE TO <u>Wremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Previous Anemia</u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>10 yrs +</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 20</u> , 1957, to <u>April 26</u> , 1957, that I last saw the deceased alive on <u>April 26</u> , 1957, and that death occurred at <u>4 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B. D. Thomas</u> M.D.				ADDRESS (Street, city or town, state) <u>Frederick, Md.</u> DATE SIGNED <u>April 26, 1957</u>			
PHYSICIAN'S NAME (Type) <u>B. D. Thomas</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>27 April 1957</u>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>New Martinsville, West Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison & Son, Frederick, Maryland</u>				24a. REC'D BY REGISTRAR <u>27 April 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth L. Herb</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04035

4934

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 8 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 206 S. Carroll St.				e. STREET ADDRESS Rural- Woodfield 15x2 2			
3. NAME OF DECEASED (Type or print) First Addie Middle D. Last Burns				4. DATE OF DEATH Month April Day 4 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 23, 1878	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 4 Days 19 Hours 57		IF UNDER 24 HRS. Months 4 Days 19 Hours 57			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Montg. Co., Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Celius Duvall				14. MOTHER'S MAIDEN NAME Sarah Catherine King			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Clayton H. Burgee, Frederick, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA of Gall bladder with 2-3 mo. metastases DUE TO 155x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastases DUE TO (c) 155x PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 155x INTERVAL BETWEEN ONSET AND DEATH 2-3 mo.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Frederick				20g. (County) Montgomery		20h. (State) Md.	
21. I certify that I attended the deceased from Feb 1957 , to April 4 1957 , that I last saw the deceased alive on April 3 1957 , and that death occurred at 9:00 a. m. from the causes and on the date stated above.							
ACTUAL SIGNATURE Rex R Martin				ADDRESS (Street, city or town, state) 35 E. Church Frederick Md			
DATE SIGNED 4-4-57							
PHYSICIAN'S NAME (Type) Rex R Martin							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 6, 1957		22c. NAME OF CEMETERY OR CREMATORY Wesley Grove		22d. LOCATION (City, town, or county) (State) Woodfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Moleworth				ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR 9 April 1957	
				24b. REGISTRAR'S SIGNATURE Elizabeth B. Hesk			

CERTIFICATE OF DEATH

Name of Deceased Frederick		Age 8 weeks		Sex Male		Race White		Date of Birth Dec 2, 1917		Place of Birth St. Louis, Mo.	
Name of Informant Frederick		Relationship Brother		Address 202 S. Carroll St.		City Baltimore		State MD.		County Harford	
Cause of Death Infantile		Period of Illness 1 week		Date of Death Dec 10, 1917		Time of Death 10:30 AM		Place of Death Home		Signature of Informant Frederick	
Signature of Physician Frederick		Signature of Informant Frederick		Signature of Informant Frederick		Signature of Informant Frederick		Signature of Informant Frederick		Signature of Informant Frederick	

BUREAU V. S.

APR 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4035

CERTIFICATE OF DEATH

04036

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>4 1/2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Walkersville</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Critchley Nursing Home</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>ELSIE</u> Middle <u>IDELLA</u> Last <u>CECIL</u>				4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>19 57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 18, 1873</u>		9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Martin Cecil</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Hewitt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Mrs. E. Clifford Hall, 240 Canale Pkwy, Fred.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. n. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>April</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 16</u> , 19 <u>57</u> , and that death occurred at <u>7:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. J. Slusher</u>				ADDRESS (Street, city or town, State) <u>9 E. Church St., Fred. Md.</u>			
PHYSICIAN'S NAME (Type) <u>H. J. SLUSHER</u>				DATE SIGNED <u>4/18/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gladys Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Walkersville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. C. Barton, Walkersville, Md</u>				24a. REC'D BY REGISTRAR DATE <u>19 April 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>April 22, 1957</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
10. SIGNATURE OF REGISTRAR <i>John Doe</i>		11. SIGNATURE OF WITNESS <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>	
16. SIGNATURE OF WITNESS <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>		21. SIGNATURE OF WITNESS <i>John Doe</i>	
22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>	
28. SIGNATURE OF WITNESS <i>John Doe</i>		29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>		33. SIGNATURE OF WITNESS <i>John Doe</i>	
34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>	
40. SIGNATURE OF WITNESS <i>John Doe</i>		41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>		45. SIGNATURE OF WITNESS <i>John Doe</i>	
46. SIGNATURE OF WITNESS <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>		51. SIGNATURE OF WITNESS <i>John Doe</i>	
52. SIGNATURE OF WITNESS <i>John Doe</i>		53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>		57. SIGNATURE OF WITNESS <i>John Doe</i>	
58. SIGNATURE OF WITNESS <i>John Doe</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF WITNESS <i>John Doe</i>	
64. SIGNATURE OF WITNESS <i>John Doe</i>		65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>		69. SIGNATURE OF WITNESS <i>John Doe</i>	
70. SIGNATURE OF WITNESS <i>John Doe</i>		71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF WITNESS <i>John Doe</i>	
76. SIGNATURE OF WITNESS <i>John Doe</i>		77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>		81. SIGNATURE OF WITNESS <i>John Doe</i>	
82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF WITNESS <i>John Doe</i>	
88. SIGNATURE OF WITNESS <i>John Doe</i>		89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>		93. SIGNATURE OF WITNESS <i>John Doe</i>	
94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF WITNESS <i>John Doe</i>	
100. SIGNATURE OF WITNESS <i>John Doe</i>		101. SIGNATURE OF WITNESS <i>John Doe</i>		102. SIGNATURE OF WITNESS <i>John Doe</i>	

RECEIVED
APR 22 1957
BUREAU V. S.

04037

4036

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Mem. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Gertie Middle Estelle Last Chaney				4. DATE OF DEATH Month April Day 21 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 31, 1877	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Fred. Co., Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Dorsey Beall				14. MOTHER'S MAIDEN NAME Emma Boyer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. George E.W. Chaney, Mt. Airy, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 904.0 Fractured ribs due to fall 2 weeks prior to death 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 5 days 15 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Fall at home during night							
20c. TIME OF INJURY Hour 6 p.m. Month Apr. Day 10 Year 1957		20d. INJURY OCCURRED While <input type="checkbox"/> at work or while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) RFDI Mt. Airy Frederick Md.	
21. I certify that I attended the deceased from June, 1956 , to Apr. 21, 1957 , that I last saw the deceased alive on April 21, 1957 , and that death occurred at 4:35 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) New Market, Maryland DATE SIGNED 4/22/57							
ACTUAL SIGNATURE Ralph L. Michels M.D.				PHYSICIAN'S NAME (Type) Ralph L. Michels			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 24, 1957		22c. NAME OF CEMETERY OR CREMATORY Marvin Chapel		22d. LOCATION (City, town, or county) (State) Plane # 4, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Molesworth ADDRESS Damascus, Md.				24a. REC'D BY REGISTRAR 25 April 1957		24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

APR 26 1957

BUREAU V. 3

RECEIVED

4067

CERTIFICATE OF DEATH

Reg. Dist. No.

145

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Myersville				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route # 2				e. STREET ADDRESS Rt. #1 Highland			
3. NAME OF DECEASED (Type or print) First Middle Last BESSIE MAE GAVER CLINE				4. DATE OF DEATH Month Day Year April 9 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1882	9. AGE (In years last birthday) yrs. 74	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME Annie Gaver			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT W.J. Cline, Myersville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Hypertension - Arteriosclerosis (c)						INTERVAL BETWEEN ONSET AND DEATH 1 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 1957, to Apr 9 1957, that I last saw the deceased alive on Apr 7 1957, and that death occurred at 11 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Elmer Harp M.D.				ADDRESS (Street, city or town, state) DATE SIGNED Middletown 4-10-57			
PHYSICIAN'S NAME (Type) J. Elmer Harp				Middletown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/11/1957		22c. NAME OF CEMETERY OR CREMATORY St. John's Luth.		22d. LOCATION (City, town, or county) (State) Nr. Myersville, Fred. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle				ADDRESS Myersville, Md.		24a. REC'D BY REGISTRAR DATE 4/15/1957	
				24b. REGISTRAR'S SIGNATURE Doyon, Bittle			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18

BUREAU V. S.

APR 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4037

04039

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Buckeystown-Frederick c. LENGTH OF STAY IN 1b 60 Yrs. 2ds d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 200 E. 6th St.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Buckeystown d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle Cockrell Last Cockrell		4. DATE OF DEATH Month April Day 7 Year 19 57	
5. SEX Female	6. COLOR OR RACE White MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> RE-MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11- 2 - 1873	9. AGE (In years last birthday) 83 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Worker		10b. KIND OF BUSINESS OR INDUSTRY Factory	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Lewis Stockman		14. MOTHER'S MAIDEN NAME Susan Fulmer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-09-7892	
17. INFORMANT Mrs. Mildred L. Eyler Address Frederick Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cardiovascular accident DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Hours			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from 7/17 , 19 57 , to 4/7 , 19 57 , that I last saw the deceased alive on 4/6 , 19 57 , and that death occurred at 10:30p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE James B. Thomas M.D. Professional Bldg. PHYSICIAN'S NAME (Type) Dr. James Thomas Frederick - Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-10-57	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery
22d. LOCATION (City, town, or county) Frederick (State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Chis. & Son ADDRESS Frederick Maryland		24a. REC'D BY REGISTRAR DATE 15 April 1957	
24b. REGISTRAR'S SIGNATURE Elizabeth S. Heck			

RECEIVED

4038

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TANEYTOWN, MARYLAND</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>				d. STREET ADDRESS <u>06x12</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Shirley Ann</u> First Middle Last <u>Conover</u>				4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 21, 1957</u>	9. AGE (In years last birthday) yrs. <u>14</u> Min. <u>36</u>	IF UNDER 1 YEAR Months <u>14</u> Days <u>36</u>		IF UNDER 24 HRS. Hours <u>14</u> Min. <u>36</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mr. Charles Conover</u>				14. MOTHER'S MAIDEN NAME <u>Geneda E. Fogle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mr. Charles Conover, Taneytown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>IMMATURITY</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <u>4/21</u> , 19 <u>57</u> , to <u>4-22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/21</u> , 19 <u>57</u> , and that death occurred at <u>6:25</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>220 N. MARKET</u> DATE SIGNED _____							
ACTUAL SIGNATURE <u>Fred J. Heldrich Jr.</u> M.D.		PHYSICIAN'S NAME (Type) <u>FRED J. HELDRICH JR. FREDERICK, MD.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/23/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Keysville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Keysville, Carroll, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u> <u>Merwyn C. Fuss Taneytown, Maryland</u>			24a. REC'D BY REGISTRAR DATE <u>24 April 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Elizabeth S. Herb</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2067332XVI

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		DATE OF BIRTH	
MANNER OF DEATH		SEX	
RACE		AGE	
EDUCATION		OCCUPATION	
MARITAL STATUS		RELIGION	
PREVIOUS ILLNESS		CAUSE OF DEATH	
IMMEDIATE CAUSE		INTERMEDIATE CAUSE	
FUNDAMENTAL CAUSE		MANNER OF DEATH	
DATE OF DEATH		PLACE OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. E.

1957

RECEIVED

THE STATE OF MARYLAND, DEPARTMENT OF HEALTH, BALTIMORE, MD. This certificate is to be filled out by the physician or other qualified person who has attended the deceased. It is to be filed in the office of the Registrar of the Department of Health, Baltimore, MD. The certificate is to be filled out in duplicate. One copy is to be filed in the office of the Registrar and the other copy is to be filed in the office of the physician or other qualified person who has attended the deceased.

4039

CERTIFICATE OF DEATH

04041

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial				d. STREET ADDRESS 627 Park Place			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Frank Middle Clinton Last Cover				4. DATE OF DEATH Month 4 Day 22 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8- -1892		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Barber		10b. KIND OF BUSINESS OR INDUSTRY Barber		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Columbus A. Cover				14. MOTHER'S MAIDEN NAME Julia			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Frank C. Cover Jr. Brunswick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion - myocardial infarction DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes mellitus DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Days - Yrs -							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/21, 1957 to 4/22, 1957 , that I last saw the deceased alive on 4/21, 1957 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Frederick, Maryland DATE SIGNED							
ACTUAL SIGNATURE James B. Thomas M.D. Frederick, Maryland				PHYSICIAN'S NAME (Type) James B. Thomas			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-24-1957		22c. NAME OF CEMETERY OR CREMATORY Pipe Creek		22d. LOCATION (City, town, or county) (State) Nr. Union Bridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE B. La Fite ADDRESS Brunswick, Maryland				24a. REC'D BY REGISTRAR DATE 4/24/57		24b. REGISTRAR'S SIGNATURE Chas. G. Beck	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED		MARRIAGE	
Name of Deceased		Name of Spouse	
Age		Age	
Sex		Sex	
Race		Race	
Date of Birth		Date of Birth	
Place of Birth		Place of Birth	
Date of Death		Date of Death	
Place of Death		Place of Death	
Cause of Death		Cause of Death	
Manner of Death		Manner of Death	
Signature of Physician		Signature of Physician	
Signature of Registrar		Signature of Registrar	
Date of Registration		Date of Registration	
Place of Registration		Place of Registration	

BUREAU V. S.

APR 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04042

4068

CERTIFICATE OF DEATH

Reg. Dist. No. 138

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#6		c. LENGTH OF STAY IN 1b 50 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#6		d. STREET ADDRESS Meadow Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Meadow Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CALVIN Middle CRONIN Last CROMWELL		4. DATE OF DEATH Month April Day 30 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 Jan 1879
9. AGE (In years last birthday) yrs. 78		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Laborer		10b. KIND OF BUSINESS OR INDUSTRY State Roads	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Cromwell		14. MOTHER'S MAIDEN NAME Annie Mary Covell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. Mary L. Cromwell		Address (Same as item #1)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days 5 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. n. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1940 to April 30, 1957 , that I last saw the deceased alive on April 30, 1957 , and that death occurred at 7:10 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE B. O. Thomas		ADDRESS (Street, city or town, state) 228 N. Market St., Frederick, Md.	
PHYSICIAN'S NAME (Type) B. O. Thomas, M. D.		DATE SIGNED 5-1-57	
22a. BURIAL, CREMATION, REBURN (Specify) Burial		22b. DATE THEREOF 5-3-57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Frederick County Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR 4-30-57		24b. REGISTRAR'S SIGNATURE Lucian K. Falconer	

RECEIVED

MAY 6 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04043

4040

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 30 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) 8 East Seventh Street				e. STREET ADDRESS 8 East Seventh Street			
3. NAME OF DECEASED (Type or print) First HARRY Middle NORMAN Last CRUM				4. DATE OF DEATH Month April Day 27 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 16 Oct 1883	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handy-man		10b. KIND OF BUSINESS OR INDUSTRY Auto Parts Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John D. Crum		14. MOTHER'S MAIDEN NAME Florence (last name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-20-3658		17. INFORMANT Address Mrs. Maggie J. E. Crum (Same as item #1)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 10 Days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 26, 1956 to April 27, 1957 , that I last saw the deceased alive on April 26, 1957 , and that death occurred at 4:40 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7 E. Church St., Frederick, Md. DATE SIGNED 4-29-57 ACTUAL SIGNATURE H. J. Slusher M.D. PHYSICIAN'S NAME (Type) H. J. Slusher, M. D.							
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 4-30-57		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 29 April 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		White		10-10-1915		New York City		10-20-1960		New York City		Heart Disease		Natural		J. Doe, M.D.		J. Doe, M.D.	
Occupation		Education		Marital Status		Previous Illnesses		Last Medical Examination		Last Hospital Admission		Last Hospital Discharge		Last Physician's Visit		Last Physician's Advice		Last Physician's Treatment		Last Physician's Prescription		Last Physician's Notes	
Teacher		High School		Married		None		10-15-1960		10-15-1960		10-15-1960		10-15-1960		10-15-1960		10-15-1960		10-15-1960		10-15-1960	
Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar	
10-20-1960		New York City		Heart Disease		Natural		J. Doe, M.D.		J. Doe, M.D.		10-20-1960		New York City		Heart Disease		Natural		J. Doe, M.D.		J. Doe, M.D.	

BUREAU V. S.

APR 30 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>4 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>W.</u> Last <u>Davis</u>				4. DATE OF DEATH Month <u>4</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/5/1868</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>88</u> Days <u>88</u> Hours <u>88</u> Min. <u>88</u>		IF UNDER 24 HRS. Months <u>88</u> Days <u>88</u> Hours <u>88</u> Min. <u>88</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired State Road Comm. Employee</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Frederick Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Howard Davis</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta M. Brashears</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs Harvey Green, Mt. Airy, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>332X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>10 yrs +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3/31</u> , 19 <u>57</u> , to <u>4/1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/1</u> , 19 <u>57</u> , and that death occurred at <u>3:30</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry V. Chase</u> M.D.				ADDRESS (Street, city or town, state) <u>4 E. Church St</u> DATE SIGNED <u>4/1/57</u>			
PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>				<u>Frederick Md</u>			
22a. BURIAL, CREMATION, REINTERMENT (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 3, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prospect</u>		22d. LOCATION (City, town, or county) (State) <u>Nr. Mt. Airy, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. N. N. N.</u> ADDRESS <u>Damascus, Md.</u>				24a. REC'D BY REGISTRAR <u>3 April 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth B. Heck</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65	
4. DATE OF DEATH April 1, 1967		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. SIGNATURE OF PHYSICIAN J. H. HARRIS	
10. SIGNATURE OF DECEASED J. H. HARRIS		11. SIGNATURE OF WITNESSES J. H. HARRIS		12. SIGNATURE OF REGISTRAR J. H. HARRIS	
13. SIGNATURE OF DECEASED J. H. HARRIS		14. SIGNATURE OF WITNESSES J. H. HARRIS		15. SIGNATURE OF REGISTRAR J. H. HARRIS	
16. SIGNATURE OF DECEASED J. H. HARRIS		17. SIGNATURE OF WITNESSES J. H. HARRIS		18. SIGNATURE OF REGISTRAR J. H. HARRIS	
19. SIGNATURE OF DECEASED J. H. HARRIS		20. SIGNATURE OF WITNESSES J. H. HARRIS		21. SIGNATURE OF REGISTRAR J. H. HARRIS	
22. SIGNATURE OF DECEASED J. H. HARRIS		23. SIGNATURE OF WITNESSES J. H. HARRIS		24. SIGNATURE OF REGISTRAR J. H. HARRIS	
25. SIGNATURE OF DECEASED J. H. HARRIS		26. SIGNATURE OF WITNESSES J. H. HARRIS		27. SIGNATURE OF REGISTRAR J. H. HARRIS	
28. SIGNATURE OF DECEASED J. H. HARRIS		29. SIGNATURE OF WITNESSES J. H. HARRIS		30. SIGNATURE OF REGISTRAR J. H. HARRIS	
31. SIGNATURE OF DECEASED J. H. HARRIS		32. SIGNATURE OF WITNESSES J. H. HARRIS		33. SIGNATURE OF REGISTRAR J. H. HARRIS	
34. SIGNATURE OF DECEASED J. H. HARRIS		35. SIGNATURE OF WITNESSES J. H. HARRIS		36. SIGNATURE OF REGISTRAR J. H. HARRIS	
37. SIGNATURE OF DECEASED J. H. HARRIS		38. SIGNATURE OF WITNESSES J. H. HARRIS		39. SIGNATURE OF REGISTRAR J. H. HARRIS	
40. SIGNATURE OF DECEASED J. H. HARRIS		41. SIGNATURE OF WITNESSES J. H. HARRIS		42. SIGNATURE OF REGISTRAR J. H. HARRIS	
43. SIGNATURE OF DECEASED J. H. HARRIS		44. SIGNATURE OF WITNESSES J. H. HARRIS		45. SIGNATURE OF REGISTRAR J. H. HARRIS	
46. SIGNATURE OF DECEASED J. H. HARRIS		47. SIGNATURE OF WITNESSES J. H. HARRIS		48. SIGNATURE OF REGISTRAR J. H. HARRIS	
49. SIGNATURE OF DECEASED J. H. HARRIS		50. SIGNATURE OF WITNESSES J. H. HARRIS		51. SIGNATURE OF REGISTRAR J. H. HARRIS	
52. SIGNATURE OF DECEASED J. H. HARRIS		53. SIGNATURE OF WITNESSES J. H. HARRIS		54. SIGNATURE OF REGISTRAR J. H. HARRIS	
55. SIGNATURE OF DECEASED J. H. HARRIS		56. SIGNATURE OF WITNESSES J. H. HARRIS		57. SIGNATURE OF REGISTRAR J. H. HARRIS	
58. SIGNATURE OF DECEASED J. H. HARRIS		59. SIGNATURE OF WITNESSES J. H. HARRIS		60. SIGNATURE OF REGISTRAR J. H. HARRIS	
61. SIGNATURE OF DECEASED J. H. HARRIS		62. SIGNATURE OF WITNESSES J. H. HARRIS		63. SIGNATURE OF REGISTRAR J. H. HARRIS	
64. SIGNATURE OF DECEASED J. H. HARRIS		65. SIGNATURE OF WITNESSES J. H. HARRIS		66. SIGNATURE OF REGISTRAR J. H. HARRIS	
67. SIGNATURE OF DECEASED J. H. HARRIS		68. SIGNATURE OF WITNESSES J. H. HARRIS		69. SIGNATURE OF REGISTRAR J. H. HARRIS	
70. SIGNATURE OF DECEASED J. H. HARRIS		71. SIGNATURE OF WITNESSES J. H. HARRIS		72. SIGNATURE OF REGISTRAR J. H. HARRIS	
73. SIGNATURE OF DECEASED J. H. HARRIS		74. SIGNATURE OF WITNESSES J. H. HARRIS		75. SIGNATURE OF REGISTRAR J. H. HARRIS	
76. SIGNATURE OF DECEASED J. H. HARRIS		77. SIGNATURE OF WITNESSES J. H. HARRIS		78. SIGNATURE OF REGISTRAR J. H. HARRIS	
79. SIGNATURE OF DECEASED J. H. HARRIS		80. SIGNATURE OF WITNESSES J. H. HARRIS		81. SIGNATURE OF REGISTRAR J. H. HARRIS	
82. SIGNATURE OF DECEASED J. H. HARRIS		83. SIGNATURE OF WITNESSES J. H. HARRIS		84. SIGNATURE OF REGISTRAR J. H. HARRIS	
85. SIGNATURE OF DECEASED J. H. HARRIS		86. SIGNATURE OF WITNESSES J. H. HARRIS		87. SIGNATURE OF REGISTRAR J. H. HARRIS	
88. SIGNATURE OF DECEASED J. H. HARRIS		89. SIGNATURE OF WITNESSES J. H. HARRIS		90. SIGNATURE OF REGISTRAR J. H. HARRIS	
89. SIGNATURE OF DECEASED J. H. HARRIS		90. SIGNATURE OF WITNESSES J. H. HARRIS		91. SIGNATURE OF REGISTRAR J. H. HARRIS	
90. SIGNATURE OF DECEASED J. H. HARRIS		91. SIGNATURE OF WITNESSES J. H. HARRIS		92. SIGNATURE OF REGISTRAR J. H. HARRIS	
91. SIGNATURE OF DECEASED J. H. HARRIS		92. SIGNATURE OF WITNESSES J. H. HARRIS		93. SIGNATURE OF REGISTRAR J. H. HARRIS	
92. SIGNATURE OF DECEASED J. H. HARRIS		93. SIGNATURE OF WITNESSES J. H. HARRIS		94. SIGNATURE OF REGISTRAR J. H. HARRIS	
93. SIGNATURE OF DECEASED J. H. HARRIS		94. SIGNATURE OF WITNESSES J. H. HARRIS		95. SIGNATURE OF REGISTRAR J. H. HARRIS	
94. SIGNATURE OF DECEASED J. H. HARRIS		95. SIGNATURE OF WITNESSES J. H. HARRIS		96. SIGNATURE OF REGISTRAR J. H. HARRIS	
95. SIGNATURE OF DECEASED J. H. HARRIS		96. SIGNATURE OF WITNESSES J. H. HARRIS		97. SIGNATURE OF REGISTRAR J. H. HARRIS	
96. SIGNATURE OF DECEASED J. H. HARRIS		97. SIGNATURE OF WITNESSES J. H. HARRIS		98. SIGNATURE OF REGISTRAR J. H. HARRIS	
97. SIGNATURE OF DECEASED J. H. HARRIS		98. SIGNATURE OF WITNESSES J. H. HARRIS		99. SIGNATURE OF REGISTRAR J. H. HARRIS	
98. SIGNATURE OF DECEASED J. H. HARRIS		99. SIGNATURE OF WITNESSES J. H. HARRIS		100. SIGNATURE OF REGISTRAR J. H. HARRIS	

BUREAU V. B.

APR 4 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04045

4042

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 234 East Sixth Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First VIRGINIA Middle ESTELLE Last DOZIER				4. DATE OF DEATH Month April Day 17 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1923		9. AGE (In years last birthday) 33 yrs.	IF UNDER 1 YEAR Months 1 Days 17 Hours 15 Min.	IF UNDER 24 HRS. Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Drug Store		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harvey R. Fox				14. MOTHER'S MAIDEN NAME Helen Stokes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-18-1736		17. INFORMANT Mr. Richard D. Dozier, Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infiltrating glioma of Brain 193X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 year DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Terminal Broncho-pneumonia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-10 , 19 56 to 4-17 , 19 57 , that I last saw the deceased alive on 4-9 , 19 57 , and that death occurred at 2:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8 East Second St., Frederick, Md. DATE SIGNED 4/18/57							
ACTUAL SIGNATURE Karl H. Tannenbaum M.D.		PHYSICIAN'S NAME (Type) Dr. Karl H. Tannenbaum Same as above					
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 20, 1957		22c. NAME OF CEMETERY OR CREMATORY Pleasant Hill Cemetery		22d. LOCATION (City, town, or county) (State) Frederick County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR 19 April 1957		24b. REGISTRAR'S SIGNATURE Elizabeth S. Heck	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES H. HARRIS		M		45		W		1910		BALTIMORE, MD		1957		BALTIMORE, MD		HEART DISEASE		NATURAL		J. H. HARRIS		J. H. HARRIS	
13. OCCUPATION		14. EDUCATION		15. MARITAL STATUS		16. RELIGION		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS TOXICITY		21. PREVIOUS ALCOHOLISM		22. PREVIOUS DRUGS		23. PREVIOUS TUBERCULOSIS		24. PREVIOUS OTHER	
None		None		Married		None		None		None		None		None		None		None		None		None	

Physician's Office of James H. Harris

James H. Harris - Registrar

BUREAU V. 2

APR 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be checked for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04046

4069

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Garfield		c. LENGTH OF STAY IN 1b 35 yrs	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Garfield (rural) Thurmont		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First MARY Middle ELIZABETH Last DRAPER		4. DATE OF DEATH Month April Day 13 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24. 1885
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME (Unknown) Newman	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Samuel Draper Smithsburg.R.D. MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 30 min. 5 yrs. ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 443x Chronic myocarditis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 2 , 1952, to April 13 , 1957, that I last saw the deceased alive on April 10 , 1957, and that death occurred at 1:0 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE M. Franklin Birely		ADDRESS (Street, city or town, state) Thurmont Md.	
PHYSICIAN'S NAME (Type) M. Franklin Birely		DATE SIGNED 4/14/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 16. 1957	
22c. NAME OF CEMETERY OR CREMATORY Mt Bethel Methodist		22d. LOCATION (City, town, or county) (State) Near Garfield Frederick Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Greaser		24. REC'D BY REGISTRAR APR 17 1957	
ADDRESS Thurmont MD		24b. REGISTRAR'S SIGNATURE W. H. Deuchy	

CERTIFICATE OF DEATH

<p>1. Name of deceased: JOHN J. LANTIER</p>		<p>2. Sex: Male</p>	
<p>3. Date of birth: 1911</p>		<p>4. Date of death: 1957</p>	
<p>5. Place of birth: NEW YORK</p>		<p>6. Place of death: BALTIMORE</p>	
<p>7. Cause of death: Heart Disease</p>		<p>8. Manner of death: Natural</p>	
<p>9. Signature of physician: [Signature]</p>		<p>10. Signature of registrar: [Signature]</p>	
<p>11. Date of registration: 1957</p>		<p>12. County: BALTIMORE</p>	

BUREAU V. 3

APR 17 1957

RECEIVED

4070

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. SMALLER TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights				c. LENGTH OF STAY IN 1b 3 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindabona Convalescent & Rest Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LUCY Middle GRACE Last FOUT				4. DATE OF DEATH Month April Day 15 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 11, 1875	
9. AGE (In years last birthday) yrs. 81		IF UNDER 1 YEAR Months 12 Days 10 Hours 10 Min.		IF UNDER 24 HRS. Hours 10 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Henry E. Smith				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Paul F. Fout, Frederick R.F.D.#6, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chr Cardiovascular Renal Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 12 hrs 10 years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Frederick, Maryland				20g. (County) (State)			
21. I certify that I attended the deceased from Jan 1 , 1957, to April 15 , 1957, that I last saw the deceased alive on April 15 , 1957, and that death occurred at 3:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) E. Second Street, Frederick, Md. DATE SIGNED 4/16/57							
ACTUAL SIGNATURE H. Lawrence Gehring M.D.				PHYSICIAN'S NAME (Type) Dr. H. L. Fahrney Same as above			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF April 17, 1957		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS Frederick, Maryland		24a. REC'D BY REGISTRAR 17 April 1957	
24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		38		M		W		JAN 15 1901		BALTIMORE, MARYLAND	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		APR 10 1937		BALTIMORE, MARYLAND	
FATHER'S NAME		MOTHER'S NAME		EDUCATION		RELIGION		MARITAL STATUS		PREVIOUS ILLNESS	
JAMES H. HARRIS		MARY J. HARRIS		HIGH SCHOOL		METHODIST		MARRIED		NONE	
DATE OF INTERVIEW		BY WHOM INTERVIEWED		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
APR 10 1937		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. 3

APR 21 8 4957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04048

Reg. Dist. No. 131

4043

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b <i>over 70 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>421 Klinehart Alley</i>				d. STREET ADDRESS 421 Klinehart Alley		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ella Middle May Last Foy				4. DATE OF DEATH Month April Day II Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 5, 1881		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Ebert				14. MOTHER'S MAIDEN NAME Emma Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Frank Ebert Address 214 E. Eight Street Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO 491X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>B.O. Thomas</i> EXAMINER'S NAME (Type) B.O. Thomas				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-13-1957		22c. NAME OF CEMETERY OR CREMATORY mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick - Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Clure & Son ADDRESS Frederick - Md.				24a. REC'D BY REGISTRAR DATE 15 April 1957		24b. REGISTRAR'S SIGNATURE <i>Elizabeth B. Heck</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

APR 16 1957

BUREAU V. 2

MAYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
Name: <u>Frederick</u>	
Age: <u>40</u>	
Sex: <u>Male</u>	
Race: <u>White</u>	
Date of Birth: <u>April 1917</u>	
Place of Birth: <u>England</u>	
Cause of Death: <u>Myocardial Infarction</u>	
Manner of Death: <u>Natural</u>	
Signature: <u>Frederick</u>	
Date: <u>April 1957</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4044

CERTIFICATE OF DEATH

Reg. Dist. No.

04049

131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Frederick</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hosp</u>				d. STREET ADDRESS <u>1510 Rosemont Ave</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Georganna Virginia Grant</u>				4. DATE OF DEATH Month Day Year <u>April 25 1957</u>			
5. SEX <u>Female</u>		6. COLOR OF RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 23 1957</u>	
9. AGE (In years last birthday) <u>2</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>2</u>		IF UNDER 24 HRS. <u>2</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>George Edward Grant</u>				14. MOTHER'S MAIDEN NAME <u>JEAN E. WASHTER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>George Edward Grant Frederick, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Miliary Atelectasis</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
INTERVAL BETWEEN ONSET AND DEATH <u>From birth</u> <u>From birth</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>23 April, 1957</u> to <u>25 April, 1957</u> that I last saw the deceased alive on <u>25 April, 1957</u> , and that death occurred at <u>1:50 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>220 N. Market St. Frederick, Md.</u> DATE SIGNED <u>25 April 1957</u>							
ACTUAL SIGNATURE <u>A. M. Powell, Jr.</u>				M.D. <u>220 N. Market St. Frederick, Md.</u>			
PHYSICIAN'S NAME (Type) <u>A. M. Powell, Jr., M. D. 220 N. Market St., Frederick, Md.</u>							
22a. BURIAL, CREMATION, REINTERMENT (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>May 26, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Blue Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Thurmont, Fred. Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Creager</u>				ADDRESS <u>Thurmont, Md</u>		24a. REC'D BY REGISTRAR <u>Elizabeth G. Heck</u>	
24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>				DATE <u>27 April 1957</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2069241XV3

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04051

147

4071

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Mt. Airy				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 rural--Mt. Airy			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prospect Rd.				d. STREET ADDRESS Prospect Rd.			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First AIRY Middle FLORENCE Last HAINES				4. DATE OF DEATH Month APRIL Day 9 Year 1957			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-27-1867		9. AGE (In years last birthday) yrs. 89	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joseph Condon				14. MOTHER'S MAIDEN NAME Caroline Brashears			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Leonard B. Haines,		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinoma of Stomach with General Metastasis 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 4, 1957 , to Apr 9, 1957 , that I last saw the deceased alive on Apr 9, 1957 , and that death occurred at 11 A. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE C. M. Van Poole M.D.				ADDRESS (Street, city or town, state) DATE SIGNED md 4/9/57			
PHYSICIAN'S NAME (Type) C. M. Van Poole							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-12-1957		22c. NAME OF CEMETERY OR CREMATORY Prospect		22d. LOCATION (City, town, or county) (State) Frederick Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,				ADDRESS Winfield, Maryland		24a. REC'D BY REGISTRAR APR 12 1957	
				24b. REGISTRAR'S SIGNATURE Mrs. Clarice Runkles			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		35		M		W		APR 4 1968		MEMPHIS, TENN.	
MAY 1932		5'10"		170		WHITE		HUSBAND		FATHER	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH	
SALES		HIGH SCHOOL		MARRIED		METHODIST		HEART DISEASE		SUICIDE	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO	
NONE		NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE		TIME		PLACE		CITY		STATE		COUNTRY	
APR 4 1968		10:15 AM		HOME		MEMPHIS		TENN.		U.S.A.	

BUREAU V. 8

APR 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04052

4045

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural New Midway</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hosp.</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>GLENN</u> Middle <u>PIERCE</u> Last <u>HOLT</u>				4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1957</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 20, 1896</u>			
9. AGE (in years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own Farm</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Charles B. Holt</u>				14. MOTHER'S MAIDEN NAME <u>Lucinda Stattlemeyer</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Mrs. Emma Holt, Le Gore, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>260x</u> DUE TO <u>Diabetes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Complete Occlusion of Arteries</u> (c) <u>as stated above</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>as stated above</u>								INTERVAL BETWEEN ONSET AND DEATH <u>none</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>April 1, 1957</u> to <u>April 26, 1957</u> , that I last saw the deceased alive on <u>April 26, 1957</u> , and that death occurred at <u>8:50 A.M.</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>H. H. Messlet</u> M.D.				DATE SIGNED <u>April 26, 1957</u>					
PHYSICIAN'S NAME (Type) <u>H. H. MESSLET</u>				ADDRESS (Street, city or town, state) <u>Amos Bridge Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/28/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>mt Hope</u>		22d. LOCATION (City, town, or county) (State) <u>Woodboro Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>G.C. Barton</u> ADDRESS <u>Walkersville, Md</u>				24a. REC'D BY REGISTRAR DATE <u>29 April 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Eligabeth G. Heck</u>			

4046

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hosp</u>				e. STREET ADDRESS <u>1412 Brunswick Street</u>			
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>A</u> Middle <u>Horan</u> Last				4. DATE OF DEATH Month <u>4</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-10-1889</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired (Engineer)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>B. & O. R. R. Co</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Frank Horan</u>				14. MOTHER'S MAIDEN NAME <u>Anna Popo</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. <u>NO</u>			
17. INFORMANT <u>Charles Horan, Gaithersburg, Maryland</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Coronary sclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>2 yrs. +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>4/9/1957</u> , to <u>4/9/1957</u> , that I last saw the deceased alive on <u>4/9/1957</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry V. Chase</u> M.D. <u>4 E. Church St</u> ADDRESS (Street, city or town, state)				DATE SIGNED <u>4/9/57</u>			
PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u> <u>Frederick Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-11-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Marks</u>		22d. LOCATION (City, town, or county) (State) <u>Petersville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. R. Felt</u> ADDRESS <u>Brunswick, Maryland</u>				24a. REC'D BY REGISTRAR <u>DATE 12-15-57</u>		24b. REGISTRAR'S SIGNATURE <u>Ely S. Hicks</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04054

4072

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Francis Scott Key Hotel		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Virginia Cromwell Houck		4. DATE OF DEATH Month Day Year April 27 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Apr. 15-1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	9. AGE (In years lost birthday) 80 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Cromwell		14. MOTHER'S MAIDEN NAME Elizabeth Frazier	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. G. Hunter Bowers-Harmony Grove, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition			INTERVAL BETWEEN ONSET AND DEATH 10 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Dec 1954, 19 to April 27, 1957, that I last saw the deceased alive on 4/27, 1957, and that death occurred at 7:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4/29/57			
ACTUAL SIGNATURE Henry V. Chase M.D.		PHYSICIAN'S NAME (Type) Dr. H.V. Chase 4 E. Church St.-Frederick-Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 1-1957	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick-Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son		ADDRESS Frederick-Maryland	24a. REC'D BY REGISTRAR DATE 2 May 1957
		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Name of Deceased Frederick J. ...		Sex Male		Age ...	
Date of Death ...		Place of Death ...		Cause of Death ...	
Occupation ...		Residence ...		Manner of Death ...	
Signature of Physician ...		Signature of Registrar ...		Signature of Coroner ...	

BUREAU V. S.

MAY 3 1957

RECEIVED

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04055

4073

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights				c. LENGTH OF STAY IN 1b 2 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 90 Vin dabona Nursing Home				d. STREET ADDRESS Mountaindale x1 Frederick RD 3			
3. NAME OF DECEASED (Type or print) First Benjamin Middle Taylor Last Kanode				4. DATE OF DEATH Month April Day 27 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 9, 1875	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Own farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Martin Kanode				14. MOTHER'S MAIDEN NAME Angaline (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Mary R. Kanode Frederick RD 3	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio Vascular Renal Disease DUE TO arteriosclerosis (c)							INTERVAL BETWEEN ONSET AND DEATH 2 weeks 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 904.1 Fracture Rt Hip Donation 4 weeks							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in浴室			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Frederick				20g. (County) Frederick		20h. (State) MD	
21. I certify that I attended the deceased from Jan , 19 54 , to April 27 , 19 57 , that I last saw the deceased alive on April 27 , 19 57 , and that death occurred at 6:30 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE H. Laurence Fahrney M.D.				ADDRESS (Street, city or town, state) Frederick MD			
DATE SIGNED							
PHYSICIAN'S NAME (Type) H. Laurence Fahrney							
22a. BURIAL, CREMATION, REBURY (Specify) Burial		22b. DATE THEREOF 4-30-57		22c. NAME OF CEMETERY OR CREMATORY Lewistown Cemetery		22d. LOCATION (City, town, or county) (State) Lewistown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Treager				ADDRESS Thurmont, Md.		24a. REC'D BY REGISTRAR DATE 30 April 1957	
24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck							

BUREAU V. S.

MAY 1 1957

RECEIVED

04056

Reg. Dist. No.

4965

1. PLACE OF DEATH a. COUNTY <i>Frederick County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brunswick</i>		c. LENGTH OF STAY IN lb <i>65 years</i> 35 <i>Brunswick</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>11 S. Maryland Ave.</i>		d. STREET ADDRESS <i>11 S. Maryland Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Sda</i> First <i>Rebecca</i> Middle <i>Kaplan</i> Last		4. DATE OF DEATH Month <i>Apr.</i> Day <i>29</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1863</i>
9. AGE (In years last birthday) yrs. <i>93</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	11. BIRTHPLACE (State or foreign country) <i>Russia</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Isidore Farb</i>	
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Myron Kaplan - Brunswick, Md.</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis</i> <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>8 1/2 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4/2</i> 19 <i>43</i> to <i>4/29</i> 19 <i>57</i> , that I last saw the deceased alive on <i>4/28</i> 19 <i>57</i> , and that death occurred at <i>10:30</i> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Brunswick, Md.</i> DATE SIGNED <i>6/4/57</i>			
ACTUAL SIGNATURE <i>J. G. F. Smith</i> M.D.		PHYSICIAN'S NAME (Type) <i>Dr. J. G. F. SMITH</i> BRUNSWICK, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/30/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Frederick Baptist Church Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Frederick, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Sal Terrano & Sons</i>		24a. REC'D BY REGISTRAR <i>1624-26 W. North Ave</i>	
24b. REGISTRAR'S SIGNATURE <i>Eugenia Burkes</i>		DATE <i>MAY 1 1957</i>	

VS A15 (4)
15M 9/55

RECEIVED

MAY 1 1957

BUREAU V. 8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04057

Reg. Dist. No. 131

4047

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>20 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hosp</u>		d. STREET ADDRESS <u>Middletown x2</u>	
3. NAME OF DECEASED (Type or print) First <u>Edgar</u> Middle <u>M.</u> Last <u>Keller</u>		4. DATE OF DEATH Month <u>4</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-11-1893</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William H. Keller</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Whitmer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-30-4631</u>	
17. INFORMANT Address <u>Mrs. Opha Keller, Middletown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the pancreas with</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized metastases</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/13/57</u> , 19 <u>57</u> , to <u>4/23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/23</u> , 19 <u>57</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry V. Chase</u>		ADDRESS (Street, city or town, state) <u>4 E. Church St</u> DATE SIGNED <u>4/24/57</u>	
PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>		<u>Frederick Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THROEF <u>4-26-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Middletown Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co., Middletown, Md.</u> ADDRESS <u></u>		24c. REC'D BY REGISTRAR <u>DATE 27 April 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04058

4048

CERTIFICATE OF DEATH

Reg. Dist. No. 13

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 3 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frank Middle Singleton Last King				4. DATE OF DEATH Month April Day 5 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 22-1887	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 70 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James H. King				14. MOTHER'S MAIDEN NAME Mary Essex King			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 218-34-1412		17. INFORMANT Mr. Carlton King-Route 4-Frederick-Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3 yrs DUE TO (c) 3 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Common Bile Duct INTERVAL BETWEEN ONSET AND DEATH 3 yrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 0 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Mar 28, 1957 to April 5, 1957 , that I last saw the deceased alive on April 5, 1957 , and that death occurred at 10:05 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John M. Culler M.D.				ADDRESS (Street, city or town, state) April 6, 57			
PHYSICIAN'S NAME (Type) Dr. John M. Culler				DATE SIGNED E. Second St.-Frederick-Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-9-1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick-Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Cline & Son				ADDRESS Frederick Md.			
24a. REC'D BY REGISTRAR 9 April 1957				24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04059

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 15				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. STREET ADDRESS 06X22			
3. NAME OF DECEASED (Type or print) First Beulah Middle Mary Last Knill				4. DATE OF DEATH Month April Day 2 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1900	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) U.S.A. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Henry Reid				14. MOTHER'S MAIDEN NAME Rhoda Stewart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 217-12-1483		17. INFORMANT George D Knill Sr.		Address Westminster 6	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed left chest, Compound DUE TO Conditions, if any, which gave rise to immediate cause (b) fracture of left knee, Shock (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH Minutes
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Head on collision with another automobile					
20c. TIME OF INJURY Month, Day, Year Hour 9 a.m. <input checked="" type="checkbox"/> p.m. <input type="checkbox"/> April 2 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 15		20f. (City or town) (County) (State) Frederick Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE B.O. Thomas				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) B.O. Thomas M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 5, 1957			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 4-5-57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick - Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son				ADDRESS Frederick - Md.		24d. REC'D BY REGISTRAR DATE 8 April 1957	
				24b. REGISTRAR'S SIGNATURE Elizabeth B. Hersh			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
John Edgar Smith		Male		35		June 15, 1922	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1234 Main Street, Baltimore, Md.		Police Officer		Heart Disease		Natural	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		HOURS OF DEATH	
April 8, 1957		10:15 AM		Home		10:00 AM	
DECEASED'S SIGNATURE		DECEASED'S ADDRESS		DECEASED'S CITY		DECEASED'S STATE	
John Edgar Smith		1234 Main Street		Baltimore		Md.	
DECEASED'S PHONE		DECEASED'S SOCIAL SECURITY		DECEASED'S MARITAL STATUS		DECEASED'S RACE	
555-1234		123-456789		Married		White	
DECEASED'S RELIGION		DECEASED'S EDUCATION		DECEASED'S EMPLOYMENT		DECEASED'S STATUS	
Roman Catholic		High School		Police Officer		Single	
DECEASED'S MOTHER'S NAME		DECEASED'S FATHER'S NAME		DECEASED'S BIRTHPLACE		DECEASED'S CITIZENSHIP	
Mary Jane Smith		John Edgar Smith		Baltimore, Md.		Naturalized	
DECEASED'S MOTHER'S ADDRESS		DECEASED'S FATHER'S ADDRESS		DECEASED'S BIRTH DATE		DECEASED'S BIRTH TIME	
1234 Main Street		1234 Main Street		June 15, 1922		10:00 AM	
DECEASED'S MOTHER'S CITY		DECEASED'S FATHER'S CITY		DECEASED'S BIRTH STATE		DECEASED'S BIRTH COUNTRY	
Baltimore		Baltimore		Md.		U.S.A.	
DECEASED'S MOTHER'S STATE		DECEASED'S FATHER'S STATE		DECEASED'S BIRTH COUNTRY		DECEASED'S BIRTH CITY	
Md.		Md.		U.S.A.		Baltimore	
DECEASED'S MOTHER'S COUNTRY		DECEASED'S FATHER'S COUNTRY		DECEASED'S BIRTH CITY		DECEASED'S BIRTH STATE	
U.S.A.		U.S.A.		Baltimore		Md.	
DECEASED'S MOTHER'S CITY		DECEASED'S FATHER'S CITY		DECEASED'S BIRTH STATE		DECEASED'S BIRTH COUNTRY	
Baltimore		Baltimore		Md.		U.S.A.	
DECEASED'S MOTHER'S STATE		DECEASED'S FATHER'S STATE		DECEASED'S BIRTH COUNTRY		DECEASED'S BIRTH CITY	
Md.		Md.		U.S.A.		Baltimore	
DECEASED'S MOTHER'S COUNTRY		DECEASED'S FATHER'S COUNTRY		DECEASED'S BIRTH CITY		DECEASED'S BIRTH STATE	
U.S.A.		U.S.A.		Baltimore		Md.	

BUREAU V. 1

APR 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G211 4-22-57 et

CERTIFICATE OF DEATH

Reg. Dist. No.

04060
13

4075

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont				c. LENGTH OF STAY IN 1b 80 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Charles NMI Knott, Sr.				4. DATE OF DEATH Month Day Year April 15 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-23-1876		9. AGE (In years last birthday) 80 81 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor			10b. KIND OF BUSINESS OR INDUSTRY Public school		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Benedict Knott				14. MOTHER'S MAIDEN NAME Margaret Stem			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Philip Tracey Thurmont, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Previous attack Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 332X (c) 3 mos							INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 12 , 19 57 to Apr. 15 , 19 57 ; that I last saw the deceased alive on Apr. 15 , 19 57 , and that death occurred at 2:50 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE James F. Gray M.D.				ADDRESS (Street, city or town, state) Thurmont Md.		DATE SIGNED 4/16/57	
PHYSICIAN'S NAME (Type) Dr. James K. Gray				Thurmont - Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-18-57		22c. NAME OF CEMETERY OR CREMATORY United Brethern Cem.		22d. LOCATION (City, town, or county) (State) Thurmont, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Berger ADDRESS Thurmont, Md.				24a. REC'D BY REGISTRAR DATE 17 April 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED J. Edgar Hoover		DATE OF DEATH April 18, 1957	
AGE 59 years		SEX Male	
RACE White		MARRIAGE Married	
BIRTH DATE April 29, 1897		BIRTH PLACE Altoona, Pa.	
EDUCATION High School		OCCUPATION Director, Federal Bureau of Investigation	
RESIDENCE Washington, D.C.		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		PLACE OF DEATH Washington, D.C.	
DATE OF BURIAL April 20, 1957		PLACE OF BURIAL Arlington National Cemetery	
SIGNATURE OF DECEASED (None)		SIGNATURE OF NEXT OF KIN (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)	

BUREAU V. S.

APR 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4049

CERTIFICATE OF DEATH

Reg. Dist. No.

04082

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 30 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) 1027 North Market Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LESTER Middle GARDNER Last LINTON				4. DATE OF DEATH Month April Day 27 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 April 1892	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Electric Corp.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Samuel Linton				14. MOTHER'S MAIDEN NAME Mary Stone			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-2099		17. INFORMANT Mrs. Mabel I. Linton (Same as item #1)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sub-arachnoid hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malignant Hypertension DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 days 5 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from April 23, 1957 to April 27, 1957 , that I last saw the deceased alive on April 26, 1957 , and that death occurred at 1:25 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE B. O. Thomas				ADDRESS (Street, city or town, state) 228 N. Market St., Frederick, Md.			
PHYSICIAN'S NAME (Type) B. O. Thomas, M. D.				DATE SIGNED 4-29-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-30-57		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 29 April 1957 - Elizabeth G. Heck		24b. REGISTRAR'S SIGNATURE	

APR 30 1957

BUREAU V. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be provided for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04063

4076

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#2		c. LENGTH OF STAY IN 1b 1 Month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Frederick				d. STREET ADDRESS 1 Near Frederick		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HENRY Middle FRANKLIN Last MAIN				4. DATE OF DEATH Month April Day 29 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 Dec 1883		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Calvin Main				14. MOTHER'S MAIDEN NAME Mary Catherine Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-36-0450		17. INFORMANT Mrs. Annie V. Main (Same as item #1)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Heart Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 28, 1957 , to April 29, 1957 , that I last saw the deceased alive on April 29, 1957 , and that death occurred at 1:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE H. J. Slusher				ADDRESS (Street, city or town, state) 7 E. Church St., Frederick, Md.		DATE SIGNED 4-30-57	
PHYSICIAN'S NAME (Type) H. J. Slusher, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-2-57		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR 2 May 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Hech	

CERTIFICATE OF DEATH

Name of Deceased George Edwin Smith		Sex Male		Age 28		Date of Birth Dec 15, 1929		Place of Birth St. Louis, Mo.		Usual Residence 1234 Main St., Baltimore, Md.		Cause of Death Heart Disease		Manner of Death Natural	
Date of Death Jan 10, 1957		Time of Death 10:30 AM		Place of Death Home		Physician's Name Dr. J. H. Jones		Hospital Name None		Burial Place Greenwood Cemetery		Burial Date Jan 12, 1957		Burial Time 11:00 AM	
Name of Informant John Doe		Relationship Brother		Address 456 Oak St., Baltimore, Md.		Telephone 555-1234		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	
Name of Informant Mary Smith		Relationship Sister		Address 789 Elm St., Baltimore, Md.		Telephone 555-5678		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	
Name of Informant James Brown		Relationship Uncle		Address 101 Pine St., Baltimore, Md.		Telephone 555-9012		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	
Name of Informant Robert White		Relationship Nephew		Address 202 Cedar St., Baltimore, Md.		Telephone 555-3456		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	
Name of Informant Sarah Green		Relationship Aunt		Address 303 Birch St., Baltimore, Md.		Telephone 555-7890		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	
Name of Informant William Black		Relationship Cousin		Address 404 Spruce St., Baltimore, Md.		Telephone 555-2345		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	
Name of Informant Elizabeth Gray		Relationship Sister-in-law		Address 505 Willow St., Baltimore, Md.		Telephone 555-6789		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	
Name of Informant Thomas King		Relationship Brother-in-law		Address 606 Ash St., Baltimore, Md.		Telephone 555-0123		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	
Name of Informant Patricia Lee		Relationship Sister		Address 707 Hickory St., Baltimore, Md.		Telephone 555-4567		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	
Name of Informant Charles Hall		Relationship Brother		Address 808 Maple St., Baltimore, Md.		Telephone 555-8901		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	
Name of Informant Anna Scott		Relationship Sister		Address 909 Poplar St., Baltimore, Md.		Telephone 555-2345		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	
Name of Informant Frank Adams		Relationship Brother		Address 1010 Walnut St., Baltimore, Md.		Telephone 555-6789		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	
Name of Informant Grace Baker		Relationship Sister		Address 1111 Chestnut St., Baltimore, Md.		Telephone 555-0123		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	
Name of Informant Henry Clark		Relationship Brother		Address 1212 Elm St., Baltimore, Md.		Telephone 555-4567		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	
Name of Informant Irene Evans		Relationship Sister		Address 1313 Oak St., Baltimore, Md.		Telephone 555-8901		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	
Name of Informant Jack Foster		Relationship Brother		Address 1414 Pine St., Baltimore, Md.		Telephone 555-2345		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	
Name of Informant Karen Gibson		Relationship Sister		Address 1515 Cedar St., Baltimore, Md.		Telephone 555-6789		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	
Name of Informant Larry Hall		Relationship Brother		Address 1616 Birch St., Baltimore, Md.		Telephone 555-0123		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	
Name of Informant Margaret Hill		Relationship Sister		Address 1717 Spruce St., Baltimore, Md.		Telephone 555-4567		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	
Name of Informant Nathan King		Relationship Brother		Address 1818 Willow St., Baltimore, Md.		Telephone 555-8901		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	
Name of Informant Olivia Lee		Relationship Sister		Address 1919 Ash St., Baltimore, Md.		Telephone 555-2345		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	
Name of Informant Peter Miller		Relationship Brother		Address 2020 Hickory St., Baltimore, Md.		Telephone 555-6789		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	
Name of Informant Quinn Scott		Relationship Sister		Address 2121 Maple St., Baltimore, Md.		Telephone 555-0123		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	
Name of Informant Rachel Taylor		Relationship Sister		Address 2222 Poplar St., Baltimore, Md.		Telephone 555-4567		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	
Name of Informant Samuel White		Relationship Brother		Address 2323 Walnut St., Baltimore, Md.		Telephone 555-8901		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	
Name of Informant Tina Young		Relationship Sister		Address 2424 Chestnut St., Baltimore, Md.		Telephone 555-2345		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	
Name of Informant Victor Adams		Relationship Brother		Address 2525 Elm St., Baltimore, Md.		Telephone 555-6789		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	
Name of Informant Wendy Baker		Relationship Sister		Address 2626 Oak St., Baltimore, Md.		Telephone 555-0123		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	
Name of Informant Xavier Clark		Relationship Brother		Address 2727 Pine St., Baltimore, Md.		Telephone 555-4567		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	
Name of Informant Yvonne Evans		Relationship Sister		Address 2828 Cedar St., Baltimore, Md.		Telephone 555-8901		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	
Name of Informant Zoe Foster		Relationship Sister		Address 2929 Birch St., Baltimore, Md.		Telephone 555-2345		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>		Signature <i>[Signature]</i>	

BUREAU V. 2

MAY 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4077

CERTIFICATE OF DEATH

04064

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Buckeystown		c. LENGTH OF STAY IN 16 Since 1917	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First INDIA Middle MAY Last MAIN		4. DATE OF DEATH Month April Day 16 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 Sept 1874
9. AGE (In years last birthday) yrs. 82		10. IF UNDER 1 YEAR Months Days Hours Min. 82	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James M. Poole		14. MOTHER'S MAIDEN NAME Mary Margaret Buxton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Alvin H. Main, 714 N. Market St., Fred'k, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO-SCLEROSIS DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH IMMED. 20+Yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1936 to 16 APR , 1957, that I last saw the deceased alive on 6 APR , 1957, and that death occurred at 8:45 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 228 N. Market St., Frederick, Md. DATE SIGNED 4/17/57 ACTUAL SIGNATURE Charles H. Conley, Jr. M.D. PHYSICIAN'S NAME (Type) Charles H. Conley, Jr., M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 18 April 1957	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR 19 April 1957	
24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck			

CERTIFICATE OF DEATH

ATLANTIC STATE DEPARTMENT OF HEALTH - BATHING 18

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. TIME OF DEATH</p>		<p>10. SIGNATURE OF PHYSICIAN</p>		<p>11. SIGNATURE OF REGISTRAR</p>		<p>12. SIGNATURE OF WITNESSES</p>	
<p>13. DATE OF DEATH</p>		<p>14. TIME OF DEATH</p>		<p>15. PLACE OF DEATH</p>		<p>16. CAUSE OF DEATH</p>	
<p>17. SIGNATURE OF PHYSICIAN</p>		<p>18. SIGNATURE OF REGISTRAR</p>		<p>19. SIGNATURE OF WITNESSES</p>		<p>20. SIGNATURE OF DECEASED</p>	
<p>21. SIGNATURE OF DECEASED</p>		<p>22. SIGNATURE OF DECEASED</p>		<p>23. SIGNATURE OF DECEASED</p>		<p>24. SIGNATURE OF DECEASED</p>	
<p>25. SIGNATURE OF DECEASED</p>		<p>26. SIGNATURE OF DECEASED</p>		<p>27. SIGNATURE OF DECEASED</p>		<p>28. SIGNATURE OF DECEASED</p>	
<p>29. SIGNATURE OF DECEASED</p>		<p>30. SIGNATURE OF DECEASED</p>		<p>31. SIGNATURE OF DECEASED</p>		<p>32. SIGNATURE OF DECEASED</p>	
<p>33. SIGNATURE OF DECEASED</p>		<p>34. SIGNATURE OF DECEASED</p>		<p>35. SIGNATURE OF DECEASED</p>		<p>36. SIGNATURE OF DECEASED</p>	
<p>37. SIGNATURE OF DECEASED</p>		<p>38. SIGNATURE OF DECEASED</p>		<p>39. SIGNATURE OF DECEASED</p>		<p>40. SIGNATURE OF DECEASED</p>	
<p>41. SIGNATURE OF DECEASED</p>		<p>42. SIGNATURE OF DECEASED</p>		<p>43. SIGNATURE OF DECEASED</p>		<p>44. SIGNATURE OF DECEASED</p>	
<p>45. SIGNATURE OF DECEASED</p>		<p>46. SIGNATURE OF DECEASED</p>		<p>47. SIGNATURE OF DECEASED</p>		<p>48. SIGNATURE OF DECEASED</p>	
<p>49. SIGNATURE OF DECEASED</p>		<p>50. SIGNATURE OF DECEASED</p>		<p>51. SIGNATURE OF DECEASED</p>		<p>52. SIGNATURE OF DECEASED</p>	
<p>53. SIGNATURE OF DECEASED</p>		<p>54. SIGNATURE OF DECEASED</p>		<p>55. SIGNATURE OF DECEASED</p>		<p>56. SIGNATURE OF DECEASED</p>	
<p>57. SIGNATURE OF DECEASED</p>		<p>58. SIGNATURE OF DECEASED</p>		<p>59. SIGNATURE OF DECEASED</p>		<p>60. SIGNATURE OF DECEASED</p>	
<p>61. SIGNATURE OF DECEASED</p>		<p>62. SIGNATURE OF DECEASED</p>		<p>63. SIGNATURE OF DECEASED</p>		<p>64. SIGNATURE OF DECEASED</p>	
<p>65. SIGNATURE OF DECEASED</p>		<p>66. SIGNATURE OF DECEASED</p>		<p>67. SIGNATURE OF DECEASED</p>		<p>68. SIGNATURE OF DECEASED</p>	
<p>69. SIGNATURE OF DECEASED</p>		<p>70. SIGNATURE OF DECEASED</p>		<p>71. SIGNATURE OF DECEASED</p>		<p>72. SIGNATURE OF DECEASED</p>	
<p>73. SIGNATURE OF DECEASED</p>		<p>74. SIGNATURE OF DECEASED</p>		<p>75. SIGNATURE OF DECEASED</p>		<p>76. SIGNATURE OF DECEASED</p>	
<p>77. SIGNATURE OF DECEASED</p>		<p>78. SIGNATURE OF DECEASED</p>		<p>79. SIGNATURE OF DECEASED</p>		<p>80. SIGNATURE OF DECEASED</p>	
<p>81. SIGNATURE OF DECEASED</p>		<p>82. SIGNATURE OF DECEASED</p>		<p>83. SIGNATURE OF DECEASED</p>		<p>84. SIGNATURE OF DECEASED</p>	
<p>85. SIGNATURE OF DECEASED</p>		<p>86. SIGNATURE OF DECEASED</p>		<p>87. SIGNATURE OF DECEASED</p>		<p>88. SIGNATURE OF DECEASED</p>	
<p>89. SIGNATURE OF DECEASED</p>		<p>90. SIGNATURE OF DECEASED</p>		<p>91. SIGNATURE OF DECEASED</p>		<p>92. SIGNATURE OF DECEASED</p>	
<p>93. SIGNATURE OF DECEASED</p>		<p>94. SIGNATURE OF DECEASED</p>		<p>95. SIGNATURE OF DECEASED</p>		<p>96. SIGNATURE OF DECEASED</p>	
<p>97. SIGNATURE OF DECEASED</p>		<p>98. SIGNATURE OF DECEASED</p>		<p>99. SIGNATURE OF DECEASED</p>		<p>100. SIGNATURE OF DECEASED</p>	

BUREAU V. 2

APR 22 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 138

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monrovia				c. LENGTH OF STAY IN 1b Years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First THOMAS Middle WILLIAM Last McDonough				4. DATE OF DEATH Month April Day 5 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 15, 1894	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 6 Days 2		IF UNDER 24 HRS. Hours 6 Min. 2			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming				10b. KIND OF BUSINESS OR INDUSTRY Owner		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Luther C. McDonough				14. MOTHER'S MAIDEN NAME Mary Remmick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW1 212-38-9672		17. INFORMANT Address Mrs. Arbelia B. McDonough, Monrovia, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.1 (c) Interval between onset and death 1 hour							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE B. O. Thomas				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. B. O. Thomas Sr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Apr. 8, 1957		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	
				22d. LOCATION (City, town, or county) (State) Frederick, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE Apr 6 1957	
				24b. REGISTRAR'S SIGNATURE Lillian K. Talbot			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4050

CERTIFICATE OF DEATH

04066

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 21 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) Frederick Memorial Hospital		e. STREET ADDRESS 315 North Bentz Street	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle HENRY Last MOSS		4. DATE OF DEATH Month April Day 24 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 March 1880
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Laborer		10b. KIND OF BUSINESS OR INDUSTRY Plumbing	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sylvester Moss		14. MOTHER'S MAIDEN NAME Margaret Harper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-0848	
17. INFORMANT Mrs. Lillie V. Moss		Address (Same as item #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemic lymphatic Anemia 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 9 mo.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 27, 1956 , to April 24, 1957 , that I last saw the deceased alive on April 24, 1957 , and that death occurred at 1:20 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert S. Turner, Jr.		ADDRESS (Street, city or town, state) 7 E. Church St., Frederick, Md.	
PHYSICIAN'S NAME (Type) Robert S. Turner, Jr., M. D.		DATE SIGNED 4-25-57	
22a. BURIAL, CREMATION, REINTERMENT (Specify) Burial	22b. DATE THEREOF 27 April 1957	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR 26 April 1957	
		24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
APR 29 1957
BUREAU V. S.

APR 29 1957

4051

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Fredrick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES EARLE MUNSHOUR		4. DATE OF DEATH Month April Day 9 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 21, 1908
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Clerk		10b. KIND OF BUSINESS OR INDUSTRY McCrory Store	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Luther Munshour		14. MOTHER'S MAIDEN NAME Lottie Eigenbrode	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-18-0708	
17. INFORMANT Lee Munshour		Address Thurmont, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Acute Myocardial Infarction DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 day 3 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 8, 1957 to April 9, 1957 , that I last saw the deceased alive on April 9, 1957 , and that death occurred at 12:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE A. A. Pearre		DATE SIGNED 4/9/57	
PHYSICIAN'S NAME (Type) Dr. A.A. Pearre			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-12-57	
22c. NAME OF CEMETERY OR CREMATORY United Brethern Cem.		22d. LOCATION (City, town, or county) (State) Thurmont Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond C. Cress		24a. REC'D BY REGISTRAR Thurmont, Md.	
24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck		DATE 11 April 1957	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
Lillian M. Lee		Female		31		White		1926		1957		Baltimore, Md.		Heart Disease		Coronary Artery Disease		Housewife		J. H. Smith		J. H. Smith	
Name of Informant		Relationship		Address		City		State		Zip		Date of Report		Signature of Informant		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician	
Lillian M. Lee		Wife		1234 N. Main St.		Baltimore		Md.		21201		1957		Lillian M. Lee		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	
Name of Informant		Relationship		Address		City		State		Zip		Date of Report		Signature of Informant		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician	
Lillian M. Lee		Wife		1234 N. Main St.		Baltimore		Md.		21201		1957		Lillian M. Lee		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	

BUREAU V. S.

APR 12 1957

RECEIVED

United Brotherhood of Carpenters and Joiners of America

Baltimore, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4052

CERTIFICATE OF DEATH

Reg. Dist. No.

04068

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 119 W. Fifth St.				d. STREET ADDRESS 119 W. Fifth St.			
3. NAME OF DECEASED (Type or print) First G. Middle Travis Last Nikirk				4. DATE OF DEATH Month April Day 5 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-12-1911		9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter-Decorator		10b. KIND OF BUSINESS OR INDUSTRY Own business		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Glen R. Nikirk (deceased)				14. MOTHER'S MAIDEN NAME Annie N. Sheffield (living)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-14-8766		17. INFORMANT Mrs. G. Travis Nikirk-119 W. 5th St.-Frederick-			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma testicle (right) DUE TO (b) (with multiple metastases - lung, liver and abdomen) DUE TO (c) 178x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 7 months 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from NOV. 10 , 19 56 , to April 5 , 19 57 , that I last saw the deceased alive on April 5 , 19 57 , and that death occurred at 2-P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Professional Bldg. Frederick-Maryland DATE SIGNED April 8, 1957							
ACTUAL SIGNATURE Bernard O. Thomas, Jr. M.D.				DATE SIGNED April 8, 1957			
PHYSICIAN'S NAME (Type) Dr. B.O. Thomas, Jr.				Frederick-Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-8-1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick-Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Cline & Son				ADDRESS Frederick-Maryland		24a. REC'D BY REGISTRAR 9 April 1957	
				24b. REGISTRAR'S SIGNATURE Elizabeth L. Herb			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED John A. Hixler		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1902		5. PLACE OF BIRTH Maryland		6. OCCUPATION Teacher	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. PLACE OF DEATH Home		10. DATE OF DEATH April 11, 1957		11. TIME OF DEATH 10:30 AM		12. SIGNATURE OF PHYSICIAN [Signature]	
13. SIGNATURE OF REGISTRAR [Signature]		14. SIGNATURE OF CLERK [Signature]		15. SIGNATURE OF WITNESS [Signature]		16. SIGNATURE OF DECEASED [Signature]		17. SIGNATURE OF NEXT OF KIN [Signature]		18. SIGNATURE OF BURIAL OFFICIAL [Signature]	
19. SIGNATURE OF FUNERAL HOME [Signature]		20. SIGNATURE OF CHURCH [Signature]		21. SIGNATURE OF CEMETERY [Signature]		22. SIGNATURE OF INTERVIEWER [Signature]		23. SIGNATURE OF SUPERVISOR [Signature]		24. SIGNATURE OF DEPARTMENT HEAD [Signature]	

BUREAU V. 2

APR 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04069

CERTIFICATE OF DEATH

Reg. Dist. No. 131

4079

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middletown				c. LENGTH OF STAY IN 1b years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First Etta Middle G. Last Norris				4. DATE OF DEATH Month 4 Day 20 Year 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/13/1864		9. AGE (In years last birthday) 93 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Joshua Norris				14. MOTHER'S MAIDEN NAME Catherine McBride			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Weldon B. Ray, Middletown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease (c) generalized arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH unknown years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) Middletown, Md.		(County) (State)	
21. I certify that I attended the deceased from February 19 56 , to April 19 57 , that I last saw the deceased alive on April 5 19 57 , and that death occurred at 2:30 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Kenneth C. Henson				ADDRESS (Street, city or town, state) Middletown, Md.		DATE SIGNED 4/22/57	
PHYSICIAN'S NAME (Type) Dr. Kenneth Henson				Middletown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4/22/1957		22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Middletown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co., Middletown, Md.				24a. REC'D BY REGISTRAR DATE 23 April 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

MEDICAL CERTIFICATION

BUREAU OF

APR 24 1957

RECEIVED

4953

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 6 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#3	
d. NAME OF HOSPITAL (If not in hospital, give street address) Frederick Memorial Hospital				d. STREET ADDRESS Walter Martz Road-Nr. Yellow Springs		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMMA Middle GERTRUDE Last POOLE				4. DATE OF DEATH Month April Day 1 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 27 June 1884	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-Wife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Alfred Young				14. MOTHER'S MAIDEN NAME Lavinia Darr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Charles E. Poole Address (Same as item #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 8 days 10 years 2 1/2
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 23, 1957 , to April 1, 1957 , that I last saw the deceased alive on April 1, 1957 , and that death occurred at 7 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Bernard O. Thomas Jr.				ADDRESS (Street, city or town, state) 228 N. Market St., Frederick, Md.			
PHYSICIAN'S NAME (Type) Bernard O. Thomas, Jr., M. D.				DATE SIGNED 4-3-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4 April 1957		22c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery		22d. LOCATION (City, town, or county) (State) Beallsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE 5 April 1957	
				24b. REGISTRAR'S SIGNATURE Elizabeth S. Heek			

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04071

Reg. Dist. No. 212

4080

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dickerson R.F.D.</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Dickerson R.F.D.</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>Rachel</u> Middle <u>Proctor</u>				4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1957</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-24-1867</u>		9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>John Bowie</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>John W. Proctor (son)</u>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO												INTERVAL BETWEEN ONSET AND DEATH <u>Hours?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE <u>B.O. Thomas</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED			
EXAMINER'S NAME (Type) <u>B.O. Thomas</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>						22b. DATE THEREOF <u>4/30/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bells Chapel</u>				22d. LOCATION (City, town, or county) <u>Dickerson Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hiltner, Brunswick, Md.</u>						ADDRESS		24a. REC'D BY REGISTRAR <u>DATE 4/29/57</u>		24b. REGISTRAR'S SIGNATURE <u>Charles W. Elgin</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

4054

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George W. Robb</u>		4. DATE OF DEATH Month Day Year <u>4 2 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 17, 1877</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Winifred E. Robb</u>		14. MOTHER'S MAIDEN NAME <u>Sadie McComas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-366344</u>	
17. INFORMANT <u>Mc Chris Robb</u>		Address <u>Cooksville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] A, B, C. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>292.2 Bronchopneumonia, bilateral, septum</u> DUE TO (b) <u>due to Hemolytic Staph. aureus</u> DUE TO (c) <u>420.0 Anteriorly located Heart Disease</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>1 WK</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/30</u> , 19 <u>57</u> , to <u>4/2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/2</u> , 19 <u>57</u> , and that death occurred at <u>1 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry V. Chase</u>		ADDRESS (Street, city or town, state) <u>4 E. Church St</u>	
PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>		DATE SIGNED <u>4/2/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-4-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>McKendall</u>	22d. LOCATION (City, town, or county) (State) <u>Cooksville, Howard, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Hargitt</u>		ADDRESS <u>Cooksville, Md.</u>	
24a. REC'D BY REGISTRAR <u>R. S. 470</u>		24b. REGISTRAR'S SIGNATURE <u>E. J. Beck</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **131**

04073
131

4955

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN 1b 36 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital				d. STREET ADDRESS 108 West Patrick Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last GERTRUDE VIRGINIA SCHAFFER				4. DATE OF DEATH Month Day Year April 30, 1957				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2 June 1920		
9. AGE (In years say birthday) 36 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert E. Eyler				14. MOTHER'S MAIDEN NAME Sarah M. Speaks				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-0345		17. INFORMANT Address William A. Schaffer (Same as item #2)				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Barbiturate Poisoning 970.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE B. O. Thomas M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) B. O. Thomas, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 30 April 1957				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-3-57		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 2 May 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND - BUREAU OF HEALTH - BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
John Doe		Male		35 years		White		May 1, 1957		Home	
Cause of Death		Manner of Death		Occupation		Education		Marital Status		Social Status	
Heart Disease		Natural		Teacher		High School		Married		Middle Class	
History of Illness		Previous Illnesses		Family History		Personal History		Mental History		Substance Use	
Chest Pain		Hypertension		No		No		No		No	
Treatment		Autopsy		Burial		Cremation		Disposition		Remarks	
Medicine		No		Yes		No		No		No	
Signature of Examiner		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Family		Signature of Other	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
 MAY 3 1957
 BUREAU V. S.

4056

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY FREDERICK MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN 1b 100	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEM. HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY MAUDE SCHILDT		4. DATE OF DEATH APRIL 7 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 8, 1890
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Milton Eby		14. MOTHER'S MAIDEN NAME Mary Ann Sharrer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Glenn Schiltd		Address Thurmont, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DISSECTING ABDOMINAL ANEURYSM 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GEN. ARTERIO-SCLEROSIS DUE TO (c) 420.0 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIO-SCLEROTIC H.D. WITH HYPERTENSION + FAILURE			INTERVAL BETWEEN ONSET AND DEATH 48 HRS 15 YRS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1951 to 7 APRIL, 1957 , that I last saw the deceased alive on 7 APRIL, 1957 , and that death occurred at 10:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles H. Conley, Jr.		DATE SIGNED 4/8/57	
PHYSICIAN'S NAME (Type) CHARLES H. CONLEY, JR.		ADDRESS (Street, city or town, state) PROFESSIONAL BLDG., FREDERICK, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/10/57	22c. NAME OF CEMETERY OR CREMATORY Cem. Church of the Brethren	22d. LOCATION (City, town, or county) (State) Rocky Ridge, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Greer		24a. REC'D BY REGISTRAR DATE 11 April 1957	
ADDRESS Thurmont		24b. REGISTRAR'S SIGNATURE Elizabeth S. Heck	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED HOUSEWIFE		SEX FEMALE	
DATE OF BIRTH JANUARY 2, 1890		PLACE OF BIRTH MARYLAND	
DATE OF DEATH APRIL 12, 1957		PLACE OF DEATH BALTIMORE, MARYLAND	
TIME OF DEATH 10:00 AM		CAUSE OF DEATH HEART DISEASE	
NAME OF PHYSICIAN DR. SCHULTZ		NAME OF HUSBAND EDWARD SCHULTZ	
NAME OF NEXT OF KIN EDWARD SCHULTZ		NAME OF BURIAL PLACE GREENWICH CEMETERY	
NAME OF FUNERAL HOME GREENWICH FUNERAL HOME		NAME OF MINISTER REV. J. H. SMITH	
NAME OF CHURCH ST. MARY'S CHURCH		NAME OF CEMETERY GREENWICH CEMETERY	
NAME OF COUNTY BALTIMORE		NAME OF STATE MARYLAND	
NAME OF CITY BALTIMORE		NAME OF DISTRICT BALTIMORE	
NAME OF WARD BALTIMORE		NAME OF BLOCK BALTIMORE	
NAME OF LOT BALTIMORE		NAME OF SECTION BALTIMORE	
NAME OF TRACT BALTIMORE		NAME OF SUBDIVISION BALTIMORE	
NAME OF PARCEL BALTIMORE		NAME OF LOT BALTIMORE	
NAME OF SECTION BALTIMORE		NAME OF TRACT BALTIMORE	
NAME OF BLOCK BALTIMORE		NAME OF LOT BALTIMORE	
NAME OF WARD BALTIMORE		NAME OF CITY BALTIMORE	
NAME OF COUNTY BALTIMORE		NAME OF STATE MARYLAND	

RECEIVED
 APR 12 1957
 BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

4000

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04075

Reg. Dist. No. 17

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>N. Va</u> b. COUNTY <u>Jefferson</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brunswick</u>		c. LENGTH OF STAY IN 1b <u>1</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harpers Ferry</u> 85x-3 ✓		d. STREET ADDRESS <u>Public Walk</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>B+C R.R. Yards</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Elwood</u> Last <u>Shipe</u>				4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 1 1913</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Car repairman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B+C R.R. Co</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Joseph L. Shipe</u>				14. MOTHER'S MAIDEN NAME <u>Ledia Virginia Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>232-10-3829</u>		17. INFORMANT <u>Mrs Mae Shipe Harpers Ferry W Va</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>B. O. Thomas</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>B. O. Thomas</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>April 17, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Luthuan</u>		22d. LOCATION (City, town, or county) (State) <u>Bolivar W Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. L. Lutz Brunswick Md</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>Eugenia N. Burke</u>	
						24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

APR 22 1957

RECEIVED

4081

CERTIFICATE OF DEATH

04076

Reg. Dist. No. 137

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Fred</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick R 2</u>	c. LENGTH OF STAY IN 1b <u>2 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2. Frederick R 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fredrick Mem. Hosp.</u>		d. STREET ADDRESS <u>_____</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Carrie Eliz. Smith</u> First Middle Last		4. DATE OF DEATH Month <u>4</u> - Day <u>29</u> - Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-19-89</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Geo Phoebus</u>		14. MOTHER'S MAIDEN NAME <u>Annie —</u>	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>(DAUGHTER) Mrs. H. Kenneth Schramm</u> Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arterio Sclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>Feb</u> 19 <u>55</u> , to <u>4-29</u> 19 <u>57</u> , that I last saw the deceased alive on <u>4-29-</u> 19 <u>57</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>35 E. Church Frederick Md</u>	DATE SIGNED <u>4-29-57</u>
ACTUAL SIGNATURE <u>Rex R Martin</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Rex R Martin</u>			

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/1/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Beth Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J Kuck</u>		24a. REC'D BY REGISTRAR <u>MAY 1 1957</u>	
ADDRESS <u>5305 Harford Rd.</u>		24b. REGISTRAR'S SIGNATURE <u>Ely H. Hicks</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG214 5-7-57 et

4082

CERTIFICATE OF DEATH

Reg. Dist. No.

04077

131

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Walkersville c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Walkersville, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Walkersville, Maryland d. STREET ADDRESS Same As Above e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sarah Middle Elizabeth Last Smith		4. DATE OF DEATH Month April Day 21 Year 19 57	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-5-1867/1866
9. AGE (In years last birthday) 90		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (State or foreign country) Frederick-Co.-Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles A. Johnson		14. MOTHER'S MAIDEN NAME Annie Unknown Maiden name	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT John H. Smith		Address Walkersville, Md. Fred. Co.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic CVD DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days 10 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 Nov. 1950 , to April 21, 1957 , that I last saw the deceased alive on April 21, 1957 , and that death occurred at 10:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 23 Apr 57			
ACTUAL SIGNATURE James H. Stoner, Jr. M.D.		PHYSICIAN'S NAME (Type) J.E. Stoner, Jr. Walkersville-Frederick-Co. Maryland	
22a. BURIAL, CREMATION, or other disposal (Specify) Burial	22b. DATE THEREOF 4-24-57	22c. NAME OF CEMETERY OR CREMATORY Silver Hill Meth. Church	22d. LOCATION (City, town, or county) (State) Mt. Pleasant Fred. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III ADDRESS Frederick, Md.		24a. REC'D BY REGISTRAR 29 April 1957	24b. REGISTRAR'S SIGNATURE Elizabeth B. Heath

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	

4083

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Bertha Elizabeth Spalding			4. DATE OF DEATH Month Day Year April 4 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 9, 1886	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Lebanon, Pennsylvania	
13. FATHER'S NAME John Phillips			14. MOTHER'S MAIDEN NAME Margie Davis		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Charles C. Spalding Address Thurmont, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart disease, st. side failure. 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Heart disease, coronary type chronic DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 40 min. 2 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Apr. 4 , 19 57 , to Apr. 4 , 19 57 , that I last saw the deceased alive on Apr. 4 , 19 57 , and that death occurred at 11:15 P. , from the causes and on the date stated above.					
ACTUAL SIGNATURE James K. Gray		ADDRESS (Street, city or town, state) Thurmont Md			
PHYSICIAN'S NAME (Type) Dr. James K. Gray		DATE SIGNED Apr. 4			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-7-57		22c. NAME OF CEMETERY OR CREMATORY United Brethern Cem.	
22d. LOCATION (City, town, or county) Thurmont		22e. (State) Maryland		22f. (County)	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Cragg		ADDRESS Thurmont, Md		24a. REC'D BY REGISTRAR APR 8 '57	
24b. REGISTRAR'S SIGNATURE Raymond E. Cragg		24c. (County)			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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John W. H. H.

CIVIL SERVICE

400

Page 6 of 10

BUREAU V. S.

APR 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04079

4057

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.D.#6		c. LENGTH OF STAY IN 1b Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.D.#6	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital			d. STREET ADDRESS Pearl		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HARVEY Middle CLAYTON Last STAUB			4. DATE OF DEATH Month April Day 23 Year 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24, 1887		9. AGE (In years last birthday) 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Cemetery		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-3324		17. INFORMANT Address Mrs. Essie Maude C. Staub, Frederick, R.D.#6, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Auricular Fibrillation DUE TO (c) Arterio-sclerotic heart dis.					INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 years 3 1/2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Angina pectoris - Uremia					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8 March, 1952 , to 23 April, 1957 , that I last saw the deceased alive on 23 April, 1957 , and that death occurred at 8:00 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Charles H. Conley Jr.		ADDRESS (Street, city or town, state) Professional Bldg., Frederick, Md. DATE SIGNED 4/24/57			
PHYSICIAN'S NAME (Type) Dr. Charles H. Conley Jr.		Same as above			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 27, 1957		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE 25 April 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Hersh	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
PLACE OF BIRTH [Faint text, possibly "Maryland"]		OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
DATE OF DEATH [Faint text, possibly "April 25, 1957"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
SIGNATURE OF DECEASED [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF PHYSICIAN [Faint signature]	
SIGNATURE OF CORONER [Faint signature]		SIGNATURE OF JURY [Faint signature]		SIGNATURE OF JUDGE [Faint signature]	

BUREAU V. S.

APR 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be separated for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE, 18

04080

4058

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. STREET ADDRESS 486 West South Street			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Ethel Middle I. Last Stockman				4. DATE OF DEATH Month April Day 9 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> SEPARATED <input type="checkbox"/>		8. DATE OF BIRTH 12-10-1886	
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ironer				10b. KIND OF BUSINESS OR INDUSTRY Laundry		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Niles A. Abrecht				14. MOTHER'S MAIDEN NAME Josephine F. Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-10-3028		17. INFORMANT Mrs. Evelyn I. Linton (daughter)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic Heart Disease 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 20 years plus							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes Mellitus Chronic cystitis				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 19, 1936 , to April 9, 1957 , that I last saw the deceased alive on April 5, 1957 , and that death occurred at 4:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Professional Bldg. DATE SIGNED 4/10/57 ACTUAL SIGNATURE L. R. Schoolman M.D. PHYSICIAN'S NAME (Type) Dr. L.R. Schoolman Frederick-Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-12-57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. C. E. Cline & Son ADDRESS Frederick-Maryland				24a. REC'D BY REGISTRAR DATE 15 April 1957		24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck	

CERTIFICATE OF DEATH

PLACE OF DEATH		RESIDENCE		DATE OF DEATH	
At Home		Baltimore, Md.		April 15, 1957	
Name of Deceased		Sex		Age	
John Doe		Male		45	
Cause of Death		Immediate Cause		Underlying Cause	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis	
Site of Death		Physician's Signature		Date of Death	
Home		[Signature]		April 15, 1957	
Manner of Death		Place of Death		Date of Death	
Natural		Home		April 15, 1957	
Occupation		Education		Date of Birth	
Teacher		High School		April 1, 1912	
Marital Status		Previous Marriages		Date of Marriage	
Single		None		None	
Social Security Number		Date of Death		Place of Death	
123-45-6789		April 15, 1957		Home	
Signature of Registrar		Signature of Physician		Date of Death	
[Signature]		[Signature]		April 15, 1957	
Name of Registrar		Name of Physician		Date of Death	
John Doe		John Doe		April 15, 1957	
Address of Registrar		Address of Physician		Date of Death	
123 Main St.		123 Main St.		April 15, 1957	
City of Registrar		City of Physician		Date of Death	
Baltimore, Md.		Baltimore, Md.		April 15, 1957	
State of Registrar		State of Physician		Date of Death	
Maryland		Maryland		April 15, 1957	
Country of Registrar		Country of Physician		Date of Death	
USA		USA		April 15, 1957	

BUREAU V. S.

APR 16 1957

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may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04081

4059

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY <u>Fredrick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fredrick</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fredrick Memorial Hospital</u>				d. STREET ADDRESS <u>RURAL</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>CATHERINE</u> Last <u>Thomas</u>				4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-17-06</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>16</u> Hours <u>16</u> Min.		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>			
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>Mary Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MARY C DOWERY</u> Address <u>UNION BRIDGE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Hypertensive Cardio-Vascular Renal Disease</u> DUE TO <u>Obesity due to over eating</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Obesity due to over eating</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>Several months</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-15</u> , 19 <u>57</u> , to <u>4-16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-16</u> , 19 <u>57</u> , and that death occurred at <u>11:00 P.M.</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>A. A. Pearre</u> M.D. <u>Fredrick, Md</u> ADDRESS (Street, city or town, state) <u></u> DATE SIGNED <u></u> PHYSICIAN'S NAME (Type) <u>A A PEARRE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT JOY</u>		22d. LOCATION (City, town, or county) (State) <u>UNION TOWN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hartzler & Sons, Union Bridge, Md</u> ADDRESS <u></u>				24a. REC'D BY REGISTRAR <u>DATE 19 April 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>	

BUREAU V. S.

APR 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4060

CERTIFICATE OF DEATH

Reg. Dist. No.

0408231

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH ELLEN VIRTIS				4. DATE OF DEATH Month Day Year 4 25 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-12-1881	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Virts				14. MOTHER'S MAIDEN NAME Elizabeth Barger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mrs. Emma Donovan, Brunswick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 260X-4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease (c) Diabetes mellitus							INTERVAL BETWEEN ONSET AND DEATH 36 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 904.0 Fracture neck left femur. Bronchopneumonia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) patient fell at home					
20c. TIME OF INJURY Month, Day, Year Hour 5 o. m. apr 8 1957 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Petersville Md	
21. I certify that I attended the deceased from 8 apr 1957 , to 25 apr 1957 , that I last saw the deceased alive on 24 apr 1957 , and that death occurred at 2 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert M. Pilgram M.D.				ADDRESS (Street, city or town, state) Prof. Bldg., Frederick, Md.		DATE SIGNED 4/25/57	
PHYSICIAN'S NAME (Type) Robert M. Pilgram							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-28-1957		22c. NAME OF CEMETERY OR CREMATORY St. Marks		22d. LOCATION (City, town, or county) (State) Petersville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Brunswick, Maryland				24a. REC'D BY REGISTRAR DATE 7 1957		24b. REGISTRAR'S SIGNATURE Ely. Kelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

Name of Deceased Elizabeth		Sex Female		Age 45		Date of Birth 0-12-1911		Place of Birth Maryland		Usual Residence Baltimore, Maryland	
Cause of Death Heart Failure		Immediate Cause Hypertension		Intermediate Cause Coronary Artery Disease		Underlying Cause Hypertension		Manner of Death Natural		Place of Death Baltimore, Maryland	
Date of Death May 2, 1957		Time of Death 10:00 AM		Physician's Signature J. Edgar Smith		Hospital or Clinic St. Mary's Hospital		City Baltimore		State Maryland	
Registrar's Signature John V. R.		Date of Registration May 7, 1957		City Baltimore		State Maryland		County Baltimore		District 10	

BUREAU V. R.

MAY 7 1957

RECEIVED

1-28-1957

Baltimore, Maryland

4084

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont				c. LENGTH OF STAY IN 1b 75 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Margaret Middle Blanche Last Waesche				4. DATE OF DEATH Month April Day 2 Year 1957			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 27, 1881	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Theodore Waesche				14. MOTHER'S MAIDEN NAME Cassandra Cover			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Grayson Shaffer Thurmont, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melanotic Carcinoma of Uterus 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. Apr. 2 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar. 2, 1957 to Apr. 2, 1957 , that I last saw the deceased alive on Apr. 2, 1957 , and that death occurred at 2:20 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James K. Gray		M.D. Thurmont - Md.		DATE SIGNED Apr. 3, 1957			
PHYSICIAN'S NAME (Type) James K. Gray		Thurmont Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-5-57		22c. NAME OF CEMETERY OR CREMATORY United Brethern Cem.		22d. LOCATION (City, town, or county) (State) Thurmont Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Crager				ADDRESS Thurmont, Md.		24a. REC'D BY REGISTRAR DATE APR 8 '57	
				24b. REGISTRAR'S SIGNATURE W. E. Seach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. Page 3 should be filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

DATE OF DEATH

Frederick

Frederick

BIRTH

Frederick

Frederick

45 yrs.

Frederick

X

Frederick

April 2

Frederick

Nov. 27, 1881

Female

U.S.A.

Maryland

MD

Frederick

Frederick

Frederick

One

C

Frederick

BUREAU V. S.

APR 8 1957

RECEIVED

United Frederick Co. Md.

1-2-57

Frederick

Frederick

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04084

4061

CERTIFICATE OF DEATH

Reg. Dist. No.

151

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
c. LENGTH OF STAY IN 1b 37 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 407 Wilson Place		d. STREET ADDRESS 407 Wilson Place	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NANNIE Middle SIMMONS Last WARFIELD		4. DATE OF DEATH Month April Day 11 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 11, 1870
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 87 Days 11 Hours 11 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Simmons		14. MOTHER'S MAIDEN NAME Eliza Harris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Russell S. Warfield, 409 Wilson Place, Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerosis DUE TO (c) 10 years.			INTERVAL BETWEEN ONSET AND DEATH 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 2 , 19 57 , to April 11 , 19 57 , that I last saw the deceased alive on April 10 , 19 57 , and that death occurred at 12:10 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Bernard O. Thomas Jr.		ADDRESS (Street, city or town, state) Professional Bldg., Frederick, Md. DATE SIGNED 4/12/1957	
PHYSICIAN'S NAME (Type) Dr. B. O. Thomas, Jr.		Same as above	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 14, 1957	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR April 1957 24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck	

BUREAU V. S.

APR 18 1957

RECEIVED

4085

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rocky Ridge		c. LENGTH OF STAY IN 1b 50 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rocky Ridge	
		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First David Middle Francis Last Wetzel		4. DATE OF DEATH Month April Day 4 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1, 1868
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer retired		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Wetzel		14. MOTHER'S MAIDEN NAME Adeline--- unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Floyd Wetzel		Address Rocky Ridge, Maryland	
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart disease - Acute rt. side failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Previous attack 6 wks ago DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 25 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 20 , 19 57 to Apr. 4 , 19 57 , that I last saw the deceased alive on Apr. 4 , 19 57 , and that death occurred at 4:06 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James K. Gray		ADDRESS (Street, city or town, state) DATE SIGNED Thurmont - Md 4-4-57	
PHYSICIAN'S NAME (Type) James K. Gray			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-7-57	
22c. NAME OF CEMETERY OR CREMATORY Mount Tabor Cemetery		22d. LOCATION (City, town, or county) (State) Rocky Ridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond C. Treagar		ADDRESS Thurmont, Md.	
24a. REC'D BY REGISTRAR APR 8		24b. REGISTRAR'S SIGNATURE	

RECEIVED

APR 8 1957

BUREAU V. S.

MURKIN STATE DEPARTMENT OF HEALTH-BALTIMORE, MD		CERTIFICATE OF DEATH	
NAME: PROCTOR		AGE: 50 yrs.	
SEX: Male		RACE: White	
DATE OF BIRTH: Feb. 1, 1908		DATE OF DEATH: April 1, 1957	
PLACE OF BIRTH: U.S.A.		PLACE OF DEATH: U.S.A.	
RESIDENCE: Rocky Ridge, Maryland		CAUSE OF DEATH: Unknown	
MANNER OF DEATH: Accident		SIGNATURE: James H. Gony	
REGISTRATION NO.: 1-7-57		FILING NO.: 1-7-57	
MOUNT TABOR CEMETERY, ROCKY RIDGE, MD.		BALTIMORE, MD.	

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 9 Film 215 5-17-57 e
4062 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

04086

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) // Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 208 West South St.				d. STREET ADDRESS 208 West South St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MIDDLE Last NETTIE E WHITTINGTON				4. DATE OF DEATH Month Day Year April 2 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1881 Jan. 27, 1880	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Orlean W. Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME John Burke				14. MOTHER'S MAIDEN NAME Mary Payne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT D.K. Address: Frederick, Md. Whittington 208 W. South St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from June 1, 19 56, to April 1, 19 57, that I last saw the deceased alive on April 1, 19 57, and that death occurred at 1:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4/2/57							
ACTUAL SIGNATURE H.J. Slysher M.D.				PHYSICIAN'S NAME (Type) 9 East Church St. Frederick, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/5/57		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. A. Horst V. Pres.				24a. REC'D BY REGISTRAR DATE 5 April 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Hersh	

BUREAU V. S.

APR 8 1957

RECEIVED

4086

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Route 15 South		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ballenger Creek Bridge				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RICHARD Middle LEE Last WILLIAMS				4. DATE OF DEATH Month April Day 2 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1930		9. AGE (In years last birthday) 26 yrs.	IF UNDER 1 YEAR Months 26 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee		10b. KIND OF BUSINESS OR INDUSTRY Farm Equip., Company		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Earl O. Williams				14. MOTHER'S MAIDEN NAME Cathern Lydia Schell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-24-9677		17. INFORMANT Address Easley, S. C. Mr. Earl O. Williams, Pecan Terrace Hotel,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Broken Neck and Crushed Esophagus 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH Instant
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto Head on in other Auto					
20c. TIME OF INJURY Month, Day, Year 8:30 Hour 4/2/ 19 57 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road		20f. (City or town) (County) (State) U.S.#15 South, Frederick, Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE B. O. Thomas Sr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Dr. B. O. Thomas Sr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 6, 1957		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE 8 April 1957	
				24b. REGISTRAR'S SIGNATURE Elizabeth S. Hark			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - BATHING 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

101

Name of Deceased		Sex		Age		Date of Death	
Place of Birth		Race		Religion		Marital Status	
Occupation		Education		Social Status		Cause of Death	
Manner of Death		Time of Death		Place of Death		Signature of Examiner	
Signature of Coroner		Signature of Physician		Signature of Medical Examiner		Signature of Registrar	

BUREAU V. 1

APR 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4063 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04088

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> d. STREET ADDRESS <u>1421 Middle Alley</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>E.</u> Last <u>Willis</u>		4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1957</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Dec. 2, 1883</u>		9. AGE (In years last birthday) <u>74</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.																
Months	Days																
Hours	Min.																
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Thomas H. Willis</u>						14. MOTHER'S MAIDEN NAME <u>Bell</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)				17. INFORMANT <u>Frederick Memorial Hospital</u> Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO <u>Decompensated Heart</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>97.0</u> DUE TO (b) <u>Decompensated Heart</u> DUE TO (c) <u>Decompensated Heart</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Burnt legs by scalding water</u>												INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>3 days</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Accidentally knocked a pan over containing hot soup</u>													
20c. TIME OF INJURY Month, Day, Year Hour <u>4 1/2</u> a. m. <u>1957</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Frederick</u> (County) <u>Frederick</u> (State) <u>Md</u>									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
ACTUAL SIGNATURE <u>B. O. Thomas</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED								
EXAMINER'S NAME (Type) <u>B. O. Thomas</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
22a. BURIAL, CREMATION, REINTERMENT (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>4-29-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FAITH VIEW</u>				22d. LOCATION (City, town, or county) (State) <u>Frederick - Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hicks</u>						ADDRESS <u>Fred, Md.</u>		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Elizabeth S. Heck</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF VENDOR		20. SIGNATURE OF CEMETERY		21. SIGNATURE OF INTERMENT	
22. SIGNATURE OF BURIAL		23. SIGNATURE OF CREMATION		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
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43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER	
58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
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79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER	
88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
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94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

RECEIVED
APR 30 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04089

4087

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#5		c. LENGTH OF STAY IN 1b 41 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old Receiver Road		e. STREET ADDRESS Old Receiver Road	
3. NAME OF DECEASED (Type or print) First MARY Middle ELLEN Last WITMER		4. DATE OF DEATH Month April Day 25 , Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Jan 1876
9. AGE (In years last birthday) yrs. 81		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Philip Hanshaw		14. MOTHER'S MAIDEN NAME Annie Elizabeth Delauter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Roy M. Witmer		Address (Same as item #1)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Anteriosclerotic Heart Disease DUE TO (Acute pulmonary edema) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 20 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 25, 1957 , to _____, 19____, that I last saw the deceased alive on April 25, 1957 , and that death occurred at 12:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert S. Turner, Jr.		ADDRESS (Street, city or town, state) 7 E. Church St., Frederick, Md.	
PHYSICIAN'S NAME (Type) Robert S. Turner, Jr., M. D.		DATE SIGNED 4-25-47	
22a. BURIAL, CREMATION, REBURY (Specify) Burial		22b. DATE THEREOF 28 April 1957	
22c. NAME OF CEMETERY OR CREMATORY Rocky Springs Cemetery		22d. LOCATION (City, town, or county) (State) Frederick County Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE 26 April 1957	
24b. REGISTRAR'S SIGNATURE Elizabeth Heck			

CERTIFICATE OF DEATH

DECEASED NAME [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
RACE [REDACTED]		DATE OF BIRTH [REDACTED]		PLACE OF BIRTH [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		MEDICAL ATTENDANT [REDACTED]	
SIGNATURE OF DECEASED [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF PHYSICIAN [REDACTED]	
SIGNATURE OF CLERK [REDACTED]		SIGNATURE OF REGISTRAR [REDACTED]		SIGNATURE OF JUDGE [REDACTED]	

BUREAU V. 3

APR 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04090

4064

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b 22 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 909 E. Patrick St.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 909 E. Patrick St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frank Middle C. Last Wright		4. DATE OF DEATH Month April Day 15 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 4, 1898 9. AGE (In years last birthday) 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner and manager		10b. KIND OF BUSINESS OR INDUSTRY Welding shop	11. BIRTHPLACE (State or foreign country) Berwick, Pa.
13. FATHER'S NAME Willard W. Wright		14. MOTHER'S MAIDEN NAME Della Martz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-30-9727	17. INFORMANT Address Wife, Mrs. Wright 909 E. Patrick St. Frederick
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Lung Cancer - Relapsed DUE TO Carcinoma of Liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 156.1 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial pneumonia		INTERVAL BETWEEN ONSET AND DEATH 1 year 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 4-15 p. m. 1957		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 22 , 19 57 , to 4-15 , 19 57 , that I last saw the deceased alive on 4-15 , 19 57 , and that death occurred at 11 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Carl H. Tannerbaum M.D.		ADDRESS (Street, city or town, state) Frederick Md DATE SIGNED 4-16-57	
PHYSICIAN'S NAME (Type) Carl H. Tannerbaum			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-17-1957	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick-Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Cline & Son ADDRESS Frederick-Maryland		24a. REC'D BY REGISTRAR DATE 17 April 1957	24b. REGISTRAR'S SIGNATURE Elizabeth A. Herb

CERTIFICATE OF DEATH

NAME OF DECEASED <i>Richard H. [illegible]</i>		AGE <i>4-10</i>		SEX <i>Male</i>		RACE <i>White</i>		DATE OF BIRTH <i>4-10-1957</i>		PLACE OF BIRTH <i>[illegible]</i>	
DATE OF DEATH <i>4-10-1957</i>		TIME OF DEATH <i>10:00 PM</i>		PLACE OF DEATH <i>Home</i>		CAUSE OF DEATH <i>[illegible]</i>		MANNER OF DEATH <i>Natural</i>		SIGNATURE OF PHYSICIAN <i>[illegible]</i>	
NAME OF NEXT OF KIN <i>[illegible]</i>		ADDRESS <i>[illegible]</i>		CITY <i>[illegible]</i>		STATE <i>MD</i>		ZIP <i>21201</i>		DATE OF INTERVIEW <i>4-10-1957</i>	
NAME OF REPORTER <i>[illegible]</i>		ADDRESS <i>[illegible]</i>		CITY <i>[illegible]</i>		STATE <i>MD</i>		ZIP <i>21201</i>		DATE OF INTERVIEW <i>4-10-1957</i>	

Richard H. [illegible]
4-10-1957
10:00 PM
Home
[illegible]
Natural
[illegible]
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APR 10-1957
BUREAU V. S.